STATE OF WASHINGTON
DEPARTMENT OF HEALTH

April 12, 2018

Matthew Crockett, CEO
Smokey Point Behavioral Hospital
3955 156th Street NE
Marysville, WA 98271

Dear Mr. Crockett:

This letter contains information regarding the recent survey of Smokey Point Behavioral Hospital by the Washington State Department of Health and the Washington State Patrol Fire Protection Bureau. Your state licensing survey was completed on March 15, 2018.

During the survey, deficient practice was found in the areas listed on the attached Statements of Deficiencies (CMS 2567). A written Plan of Correction is required for each deficiency listed on the Statement of Deficiencies and will be due 10 days after you receive this letter. All corrections for the **Health survey** must be completed within **60 days** of the survey exit date (May 14, 2018).

Each plan of correction statement must include the following:

- The regulation number and/or the tag number;
- How the deficiency will be corrected;
- Who is responsible for making the correction;
- When the correction will be completed
- How you will assure that the deficiency has been successfully corrected. When monitoring activities are planned, objectives must be measurable and quantifiable. Please include information about the monitoring time frame and number of planned observations. Also include the target for compliance and the action level that indicates the plan of correction was ineffective and that a change in the plan is needed.

A sample Plan of Correction has been enclosed for reference. You are not required to write the Plan of Correction on the Statement of Deficiencies form.

Please sign and return the original reports and Plans of Correction to me at the following address:

Lisa Mahoney, MPH, PHA
Department of Health, Investigations and Inspections Office
P.O. Box 47874
Olympia, WA 98504-7874

If more 60 days for Health corrections is required, the hospital must request an **extension/waiver**. The extension/waiver request must include the facility name; Medicare provider number and/or State license number, date of inspection; citation number; description of deficiency; description of circumstances that will not allow you to meet current deadlines; revised date of when you expect to correct the deficiency; timetable of events leading to correction (i.e. new equipment receive date, new equipment install date etc.); and steps you will take to mitigate risk to patients while the deficiency is being corrected.

Requests for extensions/waivers must be submitted to the undersigned.

Please contact me if there are questions regarding the survey process, deficiencies cited, or completion of the Plans of Correction. I may be reached at 360-236-2972 I am also available by email at lisa.mahoney@doh.wa.gov.

I want to extend another "thank you" to you and to everyone that assisted us during the survey.

Sincerely,

Lisa Mahoney
Survey Team Leader

Enclosures: DOH Statement of Deficiencies
WSP Fire Inspection Report
Sample Plan of Correction

State of Washington

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	013134	A. BUILDING: _____ B. WING _____	03/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMOKEY POINT BEHAVIORAL HOSPITAL	3955 156TH ST NE MARYSVILLE, WA 98271

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 000	INITIAL COMMENTS STATE LICENSING SURVEY The Washington State Department of Health (DOH) in accordance with Washington Administrative Code (WAC), Chapter 246-322 conducted this health and safety survey. Onsite dates: 03/05/18 - 03/09/18 and 03/12/18 -03/15/18 Examination number: 2018-123 Intake #79682 The survey was conducted by: Lisa Mahoney, MPH, PHA Elizabeth Gordon, RN, MN Kimberly Metz, MSN, BSN, RN Tyler Henning, ScM, MHS, PHA Joyce Williams, RN, BSN Paul Kondrat, RN, MN, MHA The Washington Fire Protection Bureau conducted the fire life safety inspection on 03/14/18. Refer to the Medicare Hospital Fire Life Safety Report # WOSU21. During the course of the survey, surveyors assessed issues related to complaint #2018-2823. Allegations related to patient safety, patient rights and staffing were substantiated.	L 000	1. A written PLAN OF CORRECTION is required for each deficiency listed on the Statement of Deficiencies. 2. EACH plan of correction statement must include the following: The regulation number and/or the tag number; HOW the deficiency will be corrected; WHO is responsible for making the correction; WHAT will be done to prevent reoccurrence and how you will monitor for continued compliance; and WHEN the correction will be completed. 3. Your PLANS OF CORRECTION must be returned within 10 days from the date you receive the Statement of Deficiencies. Your Plans of Correction must be postmarked by April 23, 2018. 4. Return the ORIGINAL REPORT with the required signatures.	
L 200	322-030.1 DISCLOSURE STATEMENT WAC 246-322-030 Criminal history, disclosure, and background inquiries.	L 200		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	013134	A. BUILDING: _____ B. WING _____	03/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMOKEY POINT BEHAVIORAL HOSPITAL	3955 156TH ST NE MARYSVILLE, WA 98271

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 200	Continued From page 1 (1) The licensee or license applicant shall require a disclosure statement as defined in RCW 43.43.834 for each prospective employee, volunteer, contractor, student, and any other individual associated with the hospital having direct contact with vulnerable adults as defined under RCW 43.43.830. This Washington Administrative Code is not met as evidenced by: . Based on document review and interview, the hospital failed to require a disclosure statement for prospective employees and contractors consistent with revised code of Washington (RCW) 43.43.834 for 10 of 10 files reviewed. Failure to require applicants to provide a disclosure statement pursuant to RCW 43.43.834 Child and Adult Abuse Information Act, puts patients at risk of abuse from improperly screened staff, volunteers, and contractors. Reference: RCW 43.43.834 Background checks by business, organization, or insurance company-Limitations-Civil liability. "(2) A business or organization shall require each applicant to disclose to the business or organization whether the applicant: (a) Has been convicted of a crime; (b) Has had findings made against him or her in any civil adjudicative proceeding as defined in RCW 43.43.830; or (c) Has both a conviction under (a) of this subsection and findings made against him or her under (b) of this subsection. Findings included: 1. On 03/07/18, Surveyor #4 reviewed human resource files for 10 hospital employees including	L 200		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	013134	A. BUILDING: _____ B. WING _____	03/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMOKEY POINT BEHAVIORAL HOSPITAL	3955 156TH ST NE MARYSVILLE, WA 98271

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 200	Continued From page 2 4 Registered Nurses, 2 Mental Health Technicians, 2 Program Therapists, 1 Licensed Practical Nurse and 1 Registered Dietician. The review showed no signed disclosure statements present in 10 of 10 files. 2. At the time of the review, the Human Resources Manager (Staff #409) confirmed the finding and stated that she was unaware of the State Requirement.	L 200		
L 305	322-035.1A POLICIES-ADMIT CRITERIA WAC 246-322-035 Policies and Procedures. (1) The licensee shall develop and implement the following written policies and procedures consistent with this chapter and services provided: (a) Criteria for admitting and retaining patients; This Washington Administrative Code is not met as evidenced by: Based on interview, record review, and review of hospital policies and procedures the hospital failed to develop and maintain effective systems that ensured that admitted patients received quality healthcare that met their needs in a safe environment. Failure to ensure patients are provided with care that meets acceptable standards of practice and meets the patient's healthcare needs in a safe environment risks deterioration of the patient's condition and poor healthcare outcomes. Findings included: 1. Document review of the hospital's policy titled,	L 305		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	013134	A. BUILDING: _____ B. WING _____	03/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMOKEY POINT BEHAVIORAL HOSPITAL	3955 156TH ST NE MARYSVILLE, WA 98271

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 305	Continued From page 3 "Assessment of Patients," (effective 05/17) showed that at intake, the hospital obtains information on the caller's current condition, the type of services they are seeking, who referred the patient, and appropriate disposition. The policy does not address information about the patient's physical health status, which might affect the appropriateness of their admission. Document review of the hospital's policy titled, "Medical Staff Rules and Regulations" (Effective 04/17) showed that in Chapter 3, Criteria for Admission, all admissions shall meet the inclusion criteria as established by the medical staff and that admissions shall be on the order of a physician on the Medical Staff. 2. On 03/08/18 at 1:00 PM, Surveyor #5 interviewed a Physician Assistant (Staff #519) about patients admitted to the hospital. Staff #519 stated that medically unstable patients have been denied admission by the medical provider, based on the hospital's exclusion criteria, only to have the denial superceded. He stated that patients were denied admission and then showed up on the unit the next day. 3. On 03/15/18, between 10:00 and 11:30 AM, the surveyors interviewed the hospital's governing body about admission of patients with complex medical needs. The Chief Nursing Officer (Staff #407) stated that he receives calls "a couple of times a week" from intake staff regarding appropriateness (of admission). He stated that if he does not feel confident, then he speaks with the Chief Executive Officer (Staff #410). If he approves, they go forward with screening. Patient #525	L 305		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	013134	A. BUILDING: _____ B. WING _____	03/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMOKEY POINT BEHAVIORAL HOSPITAL	3955 156TH ST NE MARYSVILLE, WA 98271

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 305	Continued From page 4 4. On 03/09/18 at 8:30 AM, Surveyor #5 reviewed the discharged medical record for Patient #525 who was admitted on 01/24/18 for the treatment of suicidal ideation that included a plan to kill himself. The medical record review showed: The Emergency Department provider notes dated 01/23/18 at 5:51 PM showed that the patient's medical history included: -Spina bifida (a spinal birth defect) -A neurogenic bladder (dysfunction of the urinary bladder due to disease of the central nervous system or peripheral nerves involved in the control of urination) -An elevated white blood cell count -A urinary tract infection -Wheelchair bound -Has an anaphylactic allergy to peanuts On 01/24/18 at 8:00 PM, a provider wrote admitting orders. Allergies were documented as "NKDA" (no known drug allergies). On 01/25/18 at 7:00 AM, the Admission Medical History and Physical Examination showed that that the patient had an allergy to peanuts, spina bifida, neurogenic bladder, a urinary tract infection, and an activity restriction of "wheelchair." Current genitourinary concerns showed that the patient catheterized himself with a Coude catheter and that he had weakness in his lower extremities. The physical assessment showed that the patient had swollen legs with atrophy related to the Spina Bifida and decreased strength in the lower extremities. Between 01/26/18 and 02/01/18, Surveyor #5	L 305		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	013134	A. BUILDING: _____ B. WING _____	03/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMOKEY POINT BEHAVIORAL HOSPITAL	3955 156TH ST NE MARYSVILLE, WA 98271

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 305	Continued From page 5 found no evidence that the provider wrote orders for the management of the patient's urinary concerns, including the need for a supply of catheterization equipment or for a bowel program related to the patient's Spina Bifida and neurogenic bladder diagnosis. On 02/02/18, the provider wrote the following order: "Straight cath (catheterization) 4-6 times daily as needed for neurogenic bladder. May use own supply until pharmacy can provide appropriate cath." On 02/05/18 at 8:00 PM, a nursing document showed that a supply of straight catheter equipment was obtained for the patient, 12 days after admission. On 03/08/18 at 1:00 PM, Surveyor #5 interviewed a provider (Staff #519) about Patient #525. During the interview, Staff #519 stated that hospital staff had removed the patient's catheter from his room and thrown it away in the biohazard trash. Staff from another shift took it out of the trash, washed it, and returned it to the patient. On 02/01/18 at 10:15 AM, a Psychiatric progress note showed that the patient had ingested a nutrition bar containing nuts. Hospital staff administered two Epinephrine Pens and 50 mg of Benadryl to the patient to control the anaphylactic response. The note also stated, "Emergency Department was called and patient was prepared for transport. Medical Director canceled transport and consulted medical." A change was entered on to the Admission provider orders where allergies had been previously documented as "NKDA" (no known drug allergies). A line was crossed through the word "NKDA" and "Peanuts Error 2/1/18 11:30 am" was written next to the	L 305		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	013134	A. BUILDING: _____ B. WING _____	03/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMOKEY POINT BEHAVIORAL HOSPITAL	3955 156TH ST NE MARYSVILLE, WA 98271

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 305	Continued From page 6 entry. On 02/01/18 at 11:00 AM, a progress note showed that the patient selected a snack at snack time and had taken a bite of it. A Physician Assistant assessed the patient and documented that the patient was having symptoms of anaphylaxis. The provider administered Epinephrine via an Epi-Pen injector. A second Physician Assistant assessed the patient and the patient received a second Epi-Pen injection. The documentation showed that the ambulance arrived, but that a Physician (Staff #515) called and "stated not to transport patient to the Emergency Room, monitor in the facility for complications." On 03/06/18 at 9:00 AM, Surveyor #11 and a provider (Staff #514) discussed the provider's concerns about the quality of care provided for Patient #525. The provider stated that she was concerned because the patient had received 2 doses of Epinephrine and the patient was not transported to an Emergency Room for further evaluation following the incident. On 03/08/18 at 1:00 PM, Surveyor #5 interviewed (Staff #519) about Patient #525. During the interview, Staff #519 stated that he ordered the patient to be transferred to an Emergency Department because the patient had received two doses of epinephrine, the hospital had no airways and no way to start an intravenous line and he felt the patient needed to be monitored closely. He stated he had written twice for the patient to be transported to the Emergency Department for evaluation but that the Medical Director had overridden the order.	L 305		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	013134	A. BUILDING: _____ B. WING _____	03/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMOKEY POINT BEHAVIORAL HOSPITAL	3955 156TH ST NE MARYSVILLE, WA 98271

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 305	Continued From page 7 Patient #504 5. On 03/12/18, Surveyor #5 reviewed the medical record of Patient #504 who was admitted on 02/06/18 for treatment of Psychosis, Suicidal Ideation, Command Auditory Hallucinations to harm self, Audio, Visual and Tactile Hallucinations, poor sleep and poor appetite. The medical record review showed the patient was a diabetic and taking metformin (a medication used to treat patients with Type 2 Diabetes). The patient nutritional screen on admission showed the patient is a Diabetic, which required the patient to receive a referral for a Nutritional consult. Surveyor #5 found no evidence the patient was referred or received a Nutritional consult. On 02/10/18 at 1:30 PM, a provider wrote an order for a medical referral because the patient had been taking metformin as an outpatient. Surveyor #5 found no evidence the patient received a medical referral for her diabetes/diabetes medication. The patient medication administration record showed that the patient did not receive metformin during her hospitalization. Patient #1101 6. On 01/26/18 at 11:00 PM, Patient #1101 was readmitted to the psychiatric hospital for psychiatric care following discharge from a medical center where the patient received care for cellulitis and diabetic ulcers on the right great toe and 2nd toe. Review of the patient's discharged medical record showed the following: On 01/27/18 at 8:30 AM, a medical consultant	L 305		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	013134	A. BUILDING: _____ B. WING _____	03/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMOKEY POINT BEHAVIORAL HOSPITAL	3955 156TH ST NE MARYSVILLE, WA 98271

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 305	Continued From page 8 (Staff #1105) completed the patient's history and physical. The history and physical examination showed that the patient had cellulitis and a diabetic foot ulcer. The medical consultant referred the patient for wound care and stated that the patient was medically stable for psychiatric treatment unless the wound worsens. The physician's order in the patient's medical record showed the medical consultant (Staff #1105) wrote an order on 01/27/18 at 8:40 AM referring the patient to a wound care clinic as soon as possible, to evaluate and treat the wound. The medical consultant's documentation dated 01/30/18 at 8:30 PM showed that the patient's diabetic foot ulcer was worsening. The medical consultant again recommended the hospital staff consult wound care. The medical consultant's documentation dated 02/02/18 at 8:45 AM showed that the patient had an open wound on the second toe of the right foot. The consultant stated that the toe needed debridement (removal of damaged tissue) and the hospital staff should follow through with the wound care referral. There was no evidence in the medical record to show that the hospital had referred the patient to a wound care clinic for treatment of the diabetic ulcers. Document review of the form titled, "Memorandum of Transfer," showed the hospital transferred Patient #1101 to a medical center on 02/05/18 at 2:55 PM for treatment of the diabetic foot ulcers.	L 305		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	013134	A. BUILDING: _____ B. WING _____	03/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMOKEY POINT BEHAVIORAL HOSPITAL	3955 156TH ST NE MARYSVILLE, WA 98271

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 305	Continued From page 9 On 03/07/18 at 5:00 PM, Surveyor #11 interviewed a registered nurse (Staff #1101) about the referral to the wound care clinic for Patient #1101. The registered nurse confirmed that the hospital did not send the patient to a wound care clinic. On 03/09/18 at 10:00 AM, Surveyor #11 reviewed the patient's medical record with the Chief Nursing Officer (Staff #1102). The Chief Nursing Officer confirmed that there was no documentation in the patient's medical record indicating that the hospital referred the patient to a wound care clinic. When the surveyor asked Staff #1102 about Patient #1101's missed medical referral, the Chief Nursing Officer stated that the registered nurse that transcribed the order was responsible for making the referral. On 03/13/18 at 3:15 PM, the Discharge Summary completed by the provider (Staff #1106) showed that the hospital transferred Patient #1101 to the emergency department at the medical center for treatment of worsening toe infection and worsening levels of pain. On 03/14/18 at 11:15 AM, Surveyor #11 interviewed a registered nurse (Staff #1103) about the process for referring Patient #1101 to the wound clinic. The registered nurse stated that at the time the order was noted by Staff #1103, a medical consultant (Staff #1105) and a nurse practitioner (Staff #1104) were there discussing the patient. The nurse stated that he thought the Nurse Practitioner would refer the patient to the wound clinic. The nurse found out later that referrals like this should be brought to the attention of the nurse manager. Staff #1103 stated that he has not received training on the hospital's process for referring patients to outside	L 305		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	013134	A. BUILDING: _____ B. WING _____	03/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMOKEY POINT BEHAVIORAL HOSPITAL	3955 156TH ST NE MARYSVILLE, WA 98271

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 305	Continued From page 10 facilities.	L 305		
L 315	322-035.1C POLICIES-TREATMENT WAC 246-322-035 Policies and Procedures. (1) The licensee shall develop and implement the following written policies and procedures consistent with this chapter and services provided: (c) Providing or arranging for the care and treatment of patients; This Washington Administrative Code is not met as evidenced by: ITEM #1- Safe from Self-Harm: Suicide Precautions Based on interview, record review, observation, and document review, the hospital failed to develop and implement a system to monitor patients that reflected the patient's risk for suicide. Failure to adequately monitor suicidal patients placed them at risk of serious injury or death. Findings included: 1. Document review of the hospital's policy and procedure titled, "Precautions: Suicide," effective date 05/17, showed "suicide" is a category the hospital used for newly admitted patients who prior to admission, had attempted suicide or had recent suicidal ideation. The policy also stated that patients placed on suicide precautions will be	L 315		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	013134	A. BUILDING: _____ B. WING _____	03/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMOKEY POINT BEHAVIORAL HOSPITAL	3955 156TH ST NE MARYSVILLE, WA 98271

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 315	Continued From page 11 checked every 15 minutes. The policy also stated that the nurse must obtain an order for "Suicide Precautions I or II," however the policy failed to define the meaning of "Suicide Precautions" and failed to specify differences between "I" and "II." The policy showed conflicting procedures for monitoring as it also directed the nurse to do the following: Review responsibilities and assign one to one supervision; Ensure the observation sheet is initiated for a patient placed on suicide precautions: Take action to adjust staffing as needed, ensuring 1:1 staff have no other duties or responsibilities: Ensure that all aspects of the suicide precautions are completed; Document review of the hospital's policy and procedure titled, "Observation Levels," effective date 05/17, showed that observation levels are defined as levels of staff awareness and attention to patient safety/security needs. The policy stated that there are specific protocols and required documentation for each observation level. Reasons for the levels of awareness included suicide risk, homicide risk, falls risk, potential for aggressive behavior, or sexually "acting out" behavior. The policy defines the levels of observation as 1:1, constant observation (Line of Sight) and Close Observation (every 15 minutes). The policy does not address or define interventions for patients who have been placed on suicide precautions or self-harm precautions to ensure patient safety and/or safe environment. 2. On 03/06/18, Surveyor #5 reviewed the discharge medical record of Patient #505 who	L 315		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	013134	A. BUILDING: _____ B. WING _____	03/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMOKEY POINT BEHAVIORAL HOSPITAL	3955 156TH ST NE MARYSVILLE, WA 98271

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 315	Continued From page 12 was admitted on 02/10/18, following a suicide attempt made 24 hours prior to admission to the hospital. On 02/22/18, a provider wrote an order to discharge the patient following administration of morning medications. The medical record review showed the following: On 02/10/18 at 3:00 AM, the Intake Call Sheet showed that the precipitating event requiring the hospitalization was a Suicide Attempt with plan to hang self, attempt to strangle self with bed sheets the prior night, and Command Auditory Hallucinations to hang himself or run into traffic. The Intake Assessment completed on admission showed that the patient was at high risk for suicide, had made prior attempts of suicide by hanging, 2 months ago and one year ago, and the patient currently reported he had ongoing suicidal ideation with plans to hang himself. On 02/10/18 at 4:30 PM, an admitting provider wrote an order to place the patient on suicide precautions and self-harm precautions with close observation and 15-minute checks. The Patient Observation Record reflected the provider's order. On 02/12/18 at 1:06 PM, a provider wrote an order to discontinue all unit restrictions. The patient observation record showed that the patient was removed from suicide precautions but remained on self-harm precautions and was checked every 15 minutes. On 02/16/2018 at 3:15 PM, the patient attempted suicide by hanging himself with his bed sheets. The report showed that the patient was initially unresponsive but responded to sternal rub and the patient was transported to an Emergency	L 315		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	013134	A. BUILDING: _____ B. WING _____	03/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMOKEY POINT BEHAVIORAL HOSPITAL	3955 156TH ST NE MARYSVILLE, WA 98271

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 315	Continued From page 13 Department at a medical hospital via ambulance. On 02/17/18 at 1:06 PM, a provider order stated to continue suicide precautions. On 02/18/18 at 5:00 PM, a provider order stated to discontinue suicide precautions, start close observation and every 15-minute checks and staff supervision was required for the patient to have blankets or beds sheets during sleep. On 02/19/18 at 11:30 AM, a nursing note showed that the patient made a second suicide attempt. The hospital transferred the patient to the 2-West unit for a higher level of care The Patient Observation Records dated 02/19/18, showed that the patient was placed on suicide precautions, self-harm precautions and every 15-minute checks. The Patient Observation Records dated 02/20/18, 02/21/18, and 02/22/18 showed that the patient was not on suicide precautions but was on self-harm precautions and every 15-minute checks. 3. On 03/06/18, Survey #5 reviewed the discharge medical record of Patient #506 who was admitted on 01/07/18 for the treatment of alcohol dependence and depression. The medical record review showed the following: The Intake Assessment completed on admission showed that the patient had attempted to kill himself the previous night by overdosing on prescription medication. The patient was reporting Command Auditory Hallucinations (CAH) to kill himself on prescription meds or by hanging himself and current suicidal ideation with	L 315		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	013134	A. BUILDING: _____ B. WING _____	03/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMOKEY POINT BEHAVIORAL HOSPITAL	3955 156TH ST NE MARYSVILLE, WA 98271

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 315	Continued From page 14 plan and access. The patient was assessed at "High Risk" for suicide with a total score of 54. On 01/07/18 at 11:02 AM, the provider wrote an order to place the patient on suicide precautions. The provider failed to indicate the "Level of Observation" on the form. The Patient Observation Record from 01/07/18 and 01/08/18 showed that the patient was on suicide precautions, self-harm precautions and checked every 15 minutes. On 01/09/18 at 5:40 PM, the patient attempted suicide by hanging himself with a bed sheet tied around his neck that had a knot tied in the other end and the knotted end placed over the top of the bathroom door. Following the incident, a provider ordered a 1:1 sitter "stat" (immediately) and a medical consult for suicide attempt via hanging. The Patient Observation Record from 01/09/18 and 01/10/18, showed that the patient was on suicide precautions, self-harm precautions, 1:1, and checked every 15 minutes. On 01/10/18 at 2:00 PM, a provider wrote an order to discontinue the 1:1 monitoring and start Line of Sight monitoring. On 01/11/18 at 10:45 AM, a provider wrote an order to continue line of sight, every 5-minute night checks but the form used for documentation only identified 15-minute checks. 4. On 03/06/18, Surveyor #5 reviewed the discharge medical record of Patient #507 who was admitted on 02/09/18 for major depressive disorder and post-traumatic stress disorder. The	L 315		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	013134	A. BUILDING: _____ B. WING _____	03/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMOKEY POINT BEHAVIORAL HOSPITAL	3955 156TH ST NE MARYSVILLE, WA 98271

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 315	Continued From page 15 medical record review showed the following: The Intake Assessment showed that the patient had physically assaulted his father, had increased aggressive behavior toward family, and per the family, had been sleeping with a knife under his pillow. The patient was assessed at moderate risk of suicide. On 02/09/18 at 12:00 PM, the admitting provider ordered the patient placed on close observation with 15-minute checks. On 02/15/18 at 9:30 PM, hospital staff found the patient in his room with a flat sheet tied into a noose. A nursing progress note shows that staff texted a picture of the noose to the Chief Nursing Officer (CNO), (Staff #501) and that the nurse manager was contacted to determine if 1:1 staffing was available. The note stated, "It was determined that all clothing and bedding, except for fitted sheet and blanket would be removed and the patient would be observed aggressively. Consequently, patient was rounded on (every) 15 minutes." Surveyor #5 found no evidence in the medical record that hospital staff notified the physician about the event nor did the record show any evidence of orders to increase monitoring. The Patient Observation Records for 02/16/18 through the patient's discharge on 02/20/18 showed that the patient was on suicide precautions with every 15-minute monitoring. 5. On 03/07/18 at 11:08 AM, Surveyor #5 and a Registered Nurse (Staff #508) reviewed the medical record for Patient #508 who was admitted on 02/15/18 for the treatment of	L 315		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	013134	A. BUILDING: _____ B. WING _____	03/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMOKEY POINT BEHAVIORAL HOSPITAL	3955 156TH ST NE MARYSVILLE, WA 98271

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 315	Continued From page 16 post-traumatic stress disorder, depression, and suicide attempt. The Intake Assessment completed on admission showed that the patient had self-harm behavior, a history of suicide attempts, and had taken a knife with her to her provider appointment and made threats to stab herself. The patient was assessed at high risk for suicide. On 02/15/18 at 9:45 AM, a provider wrote an order to place the patient on suicide precautions with close observation and every 15-minute checks. On the same date, The Patient Observation record reflected the 15-minute checks, but the record did not include suicide precautions until 02/16/18. On 02/17/18 at 11:00 AM, a Psychiatric progress note stated, "(Patient #508) attempted to hang herself this a.m., and verbalizes her continued desire to die as she no longer wants to deal with her mental illness." On 02/17/18 at 11:05 AM, a provider wrote an order to begin room lockout and self-harm precautions. On 02/20/18 at 9:00 PM, a Registered Nurse progress note showed that the patient alerted staff that she was suicidal and wanted to harm herself. Staff initiated 1:1 monitoring to keep the patient safe. On 02/20/18 at 11:30 PM, a provider wrote an order to increase security to every 5-minute checks for suicidal ideation. The Patient Observation Record reflected the increased frequency of patient checks.	L 315		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	013134	A. BUILDING: _____ B. WING _____	03/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMOKEY POINT BEHAVIORAL HOSPITAL	3955 156TH ST NE MARYSVILLE, WA 98271

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 315	Continued From page 17 On 02/22/18 at 12:00 PM, a provider wrote an order to discontinue line of sight. 6. On 03/07/18, Surveyor #5 reviewed the medical record of Patient #509, who was admitted on 02/16/18 for the treatment of suicidal ideation and bipolar disorder. The Intake Assessment completed on admission showed that the patient presented with suicidal ideation with a plan to run into a train and a long history of suicidal ideation with multiple attempts. The patient was assessed at "High Risk" for suicide. On 02/17/18 at 12:10 AM, the admitting provider wrote an order to place the patient on close observation with 15-minute checks. The patient was not placed on suicide precautions, however the Patient Observation records from 02/16-02/19/18 indicated the patient was on "self-harm precautions". On 02/18/18 at 6:00 PM, a provider wrote an order to begin self-harm precautions. On 02/18/18, an untimed Registered Nurse's note showed that the patient was banging her head into the wall and had suicidal ideation with a plan to commit suicide by "banging her head as hard as she can into the wall." - Surveyor #5 could find no evidence in the record that staff took precautions to prevent the patient from banging her head. 7. On 03/08/18, Surveyor #5 reviewed the medical record for Patient #512, who was admitted on 03/03/18 for the treatment of unspecified depression after she attempted	L 315		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	013134	A. BUILDING: _____ B. WING _____	03/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMOKEY POINT BEHAVIORAL HOSPITAL	3955 156TH ST NE MARYSVILLE, WA 98271

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 315	Continued From page 18 suicide by overdosing on clonazepam (an anti-anxiety drug), and alcohol which resulted in a motor vehicle accident. The medical record review showed the following: The Intake Assessment completed on admission showed that the patient had current suicidal ideation with a plan, intent, and access, and had drove her car into traffic. The patient was assessed at "High Risk" for suicide. On 03/03/18 at 9:30 AM, the provider wrote an order for unit restrictions. The provider did not order suicide precautions with every 15-minute checks until 3 days later on 03/06/18 at 8:00 PM. 8. On 03/05/18 at 2:20 PM, Surveyor #5 interviewed a Mental Health Technician (Staff #504) about what it meant to be on suicide or assault precautions. Staff #504 stated that it meant that staff needed to be aware of the patient's actions. 9. On 03/06/18 at 4:00 PM, Surveyor #5 interviewed the Chief Nursing Officer (CNO) (Staff #501) about the suicide attempt findings and the hospital's policy and procedures for patients admitted at risk for suicide. Staff #501 stated that actively suicidal patients should be placed on 1:1 monitoring. 10. On 03/07/18 at 11:44 AM, Surveyor #5 interviewed a Registered Nurse (Staff #507) about suicide precautions for patients who are admitted at risk for suicide. Staff #507 stated that patients are "only put on 1:1 monitoring if they do something at this facility." 11. On 03/07/18 at 12:05 PM, Surveyor #5 interviewed a Registered Nurse (Staff #508)	L 315		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	013134	A. BUILDING: _____ B. WING _____	03/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMOKEY POINT BEHAVIORAL HOSPITAL	3955 156TH ST NE MARYSVILLE, WA 98271

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 315	Continued From page 19 about the hospital's policy and procedure for patient assessed at risk for suicide. Staff #508 stated that when patients are on suicide precautions, they get their room checked every day and they get no extra linen. She stated that suicidal patients are supposed to have safety blankets, but they are not available. She stated that the department was very busy and had many suicide attempts. She stated that recently 3 patients attempted suicide on her shift on the same day, there was not enough staff, and so they locked all the patients out of their rooms for safety. She stated that she felt "it was only a matter of time until someone dies, because when patients need 1:1 staff for safety there is no one available help". 12. On 03/08/18 at 11:00 AM, Surveyor #5 interviewed a Registered Nurse (Staff #509) and a Mental Health Technician (Staff #510) about the hospital's policies and procedures for monitoring patients at risk for suicide or those on suicide precautions. Staff #509 and Staff #510 stated that there was no difference in the monitoring. Patients on suicide risk precautions received the same 15-minutes checks as all other patients in the unit. ITEM #2- Safe from Self Harm/Harm to Others: Line of Sight Precautions Based on interview, record review, observation, and review of policy and procedure, the hospital failed to develop and implement a system to ensure the safety of 4 of 4 patients (Patient #501, #502, #503, and #504) who had been placed on line of sight precautions for being a danger to self or others.	L 315		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	013134	A. BUILDING: _____ B. WING _____	03/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMOKEY POINT BEHAVIORAL HOSPITAL	3955 156TH ST NE MARYSVILLE, WA 98271

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 315	Continued From page 20 Failure to protect patients from self-harm and harm by other patients and failure to properly communicate patients' risk of self-harm, harm to other patients or harm to unit staff members, posed a serious threat to the health and safety of all patients and staff, which could result in serious injury and death. Findings included: 1. Document review of the hospital's policy and procedure titled, "Observation Levels," effective date 05/17, showed that patients placed in Line of Sight (LOS) precautions should be in visual range of the assigned staff at all times. Document review of the hospital's policy and procedure titled, "Precaution: Suicide," effective date 05/17, showed that LOS precautions is a level of precaution used for patients who represent an active suicide risk. 2. On 03/05/18 at 1:40 PM, Surveyor #5, a Registered Nurse (Staff #502) and the Director of Education and Infection Prevention (Staff #503) inspected the hospital's 2-North unit. At the time of the inspection, Surveyor #5 asked Staff #502 and Staff #503 if there were any patients on the unit who were in restraint/seclusion, or on suicide, 1:1, or LOS precautions. Staff #502 and #503 stated that there were no patients on the unit in restraint/seclusion, or on suicide, 1:1, or LOS precautions. 3. On 03/05/18 at 2:10 PM, Surveyor #5 reviewed the medical record of Patient #501 who was admitted on 02/24/18 for stabilization and treatment of continuing suicidal ideation (SI) with intention to harm herself. The patient was previously diagnosed with bipolar disorder,	L 315		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	013134	A. BUILDING: _____ B. WING _____	03/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMOKEY POINT BEHAVIORAL HOSPITAL	3955 156TH ST NE MARYSVILLE, WA 98271

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 315	Continued From page 21 self-injurious behavior by cutting herself, auditory hallucinations, a history of three suicide attempts, and an attempt to choke herself on a previous admission to Smokey Point Behavioral Hospital. The medical record review showed: On 02/25/18 at 1:45 AM, the patient was assessed at high risk for suicide and placed on suicide precautions. On 03/01/18, the provider placed the patient on 1:1 monitoring for disruptive behavior. On 03/02/18, a physician discontinued the 1:1 monitoring and placed the patient on LOS monitoring with directions to "keep out of room during daytime, must stay by nursing station. Q5 minute (every five minutes) checks while in bed." On 03/03/18, the hospital moved the patient to the 2-North unit after she assaulted multiple staff members. On 03/04/18 and 03/05/18, the daily observation sheets showed the patient was on suicide, self-harm, assault/homicide precautions but was only on every 15 minute checks, not LOS monitoring or Q5 minute checks while in bed. On 03/05/18 at 4:30 PM, Surveyor #5 reviewed the hospital's list for LOS precautions provided by the Chief Nursing Officer (Staff #501). The list did not include Patient #501. On 03/05/18 at 2:30 PM, Surveyor #5 interviewed the Charge Nurse (Staff #502) about monitoring for Patient #501. Staff #502 confirmed the physician order for LOS precautions and stated that the patient was not being monitored on LOS. 4. On 03/05/18 at 2:35 PM, Surveyor #5 and Staff	L 315		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	013134	A. BUILDING: _____ B. WING _____	03/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMOKEY POINT BEHAVIORAL HOSPITAL	3955 156TH ST NE MARYSVILLE, WA 98271

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 315	Continued From page 22 #502 reviewed the medical record of Patient #502, who was located on the 2-North unit and who was admitted on 10/30/17 for the treatment of Schizoaffective disorder, Bipolar type F25, and anorexia/bulimia. The medical record review showed the following: Prior to transfer to this hospital, the patient assaulted a nurse and a security officer in the emergency department and the patient continued to exhibit disorganized and disruptive behavior. On 02/08/18 at 8:00 PM, a physician wrote an order for the patient to be on LOS precautions while in the milieu and have every 15-minute checks while in the bedroom. On 03/05/18 at 2:44 PM, Surveyor #5 interviewed the Charge Nurse (Staff #502) about the observation status for Patient #502. The Charge Nurse confirmed the physician order for LOS precautions and stated that the hospital staff was not monitoring the patient consistent with the provider's order. On 03/05/18 at 4:30 PM, Surveyor #5 reviewed the hospital's list for LOS precautions provided by the Chief Nursing Officer (Staff #501). The list did not include Patient #502. 5. On 03/12/18, Surveyor #5 reviewed the medical records for Patient #503 and #504, who were located on the 2-West unit. The review of their medical records showed both patients received provider orders for line of sight monitoring. On 03/13/18 at 8:50 AM, Surveyor #5 and the Senior Vice President of Clinical Services (Staff #505) observed the 2-West unit as staff	L 315		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	013134	A. BUILDING: _____ B. WING _____	03/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMOKEY POINT BEHAVIORAL HOSPITAL	3955 156TH ST NE MARYSVILLE, WA 98271

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 315	Continued From page 23 performed LOS precautions. The observation showed there was no staff performing LOS monitoring. Surveyor #5 and Staff #505 interviewed a Mental Health Technician (MHT) (Staff #506), who at the time was reviewing paperwork behind the nurse's station, about the patients on the units with LOS monitoring for harm to self or others. The MHT stated that there was only one person on LOS monitoring and pointed toward Patient #504, but failed to identify Patient #503. Surveyor #5, Staff #505, and Staff #506 reviewed the medical record for Patient #503 for any change in the physician LOS orders. The medical record review showed no change in the physician order. 6. On 03/05/18 at 2:20 PM, Surveyor #5 interviewed a Mental Health Technician (Staff #504) about staff monitoring of patients on safety precautions. Staff #504 stated that there is no designated person to do LOS monitoring. She stated that there used to be extra staff when patients were placed on LOS monitoring to watch them but that no longer happens. Surveyor #5 asked Staff #504 what happens when there are multiple patients on LOS. Staff #504 stated that sometimes they do "lock outs" (locking all the patient room doors so patents cannot enter their room unless let in by a staff member) to keep patients in the milieu so they can be observed. Item #3- Nutritional Screen Based on review of hospital policies and procedure and review of medical records, the hospital failed to ensure that staff referred a	L 315		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	013134	A. BUILDING: _____ B. WING _____	03/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMOKEY POINT BEHAVIORAL HOSPITAL	3955 156TH ST NE MARYSVILLE, WA 98271

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 315	Continued From page 24 patient for a nutritional consult with a dietician for evaluation of nutritional deficiencies. . Failure to refer a patient for a nutritional consult may lead to poor nutrition and poor health outcomes. . Finding included: 1. Document review of the hospital's form titled, "Nutritional Screen," showed that patients were to receive a referral for a nutritional consult when any of the referenced conditions were identified in a patient's screening. This included: -Poor appetite -Diabetes -Underweight -Chronic constipation -Medical condition that requires nutritional intervention -On medications that may interact with foods -Taking nutritional supplements at home -Lactose intolerant -Pregnant-History of eating disorder -Obese -Signs of malnutrition Unplanned weight gain or loss -Chewing, swallowing problems -History of chronic dieting -Nausea and vomiting more than 3 days 2. Surveyor #9 reviewed the medical record of patient #911 whose nutritional screening showed that the patient had a poor appetite and was taking nutritional supplements at home; however, there was no evidence in the patient's record that staff requested a nutritional consult. 3. On 03/12/18, Surveyor #5 reviewed the medical record of Patient #504 who was admitted	L 315		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	013134	A. BUILDING: _____ B. WING _____	03/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMOKEY POINT BEHAVIORAL HOSPITAL	3955 156TH ST NE MARYSVILLE, WA 98271

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 315	Continued From page 25 on 02/06/18 for treatment of Psychosis, Suicidal Ideation, Command Auditory Hallucinations to harm self, Audio, Visual and Tactile Hallucinations, poor sleep and poor appetite. The medical record review showed the patient was a diabetic and taking metformin (a medication used to treat patients with Type 2 Diabetes). The patient's nutritional screen on admission showed the patient is a Diabetic, which required a referral for a Nutrition consult. Surveyor #5 found no evidence staff requested a Nutritional consult for the patient.	L 315		
L 320	322-035.1D POLICIES-PATIENT RIGHTS WAC 246-322-035 Policies and Procedures. (1) The licensee shall develop and implement the following written policies and procedures consistent with this chapter and services provided: (d) Assuring patient rights according to chapters 71.05 and 71.34 RCW, including posting those rights in a prominent place for the patients to read; This Washington Administrative Code is not met as evidenced by: Item #1- Privacy Based on observation, interview, and document review, the hospital failed to protect a patient's right to personal privacy. Failure to provide for privacy puts patients at risk for loss of personal dignity and psychological harm.	L 320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	013134	A. BUILDING: _____ B. WING _____	03/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMOKEY POINT BEHAVIORAL HOSPITAL	3955 156TH ST NE MARYSVILLE, WA 98271

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 320	Continued From page 26 Findings included: 1. Document review of the hospital's policy and procedure titled, "Unclothed Body Search/Property Search," no policy number, revised 05/17, showed that at all times, staff must protect the privacy and dignity of the patient during the search procedure. Staff members of the same gender as the patient must perform the search in complete privacy. Document review of the hospital's policy and procedure titled, "Patient Rights," no policy number, effective 05/17, showed that the hospital shall recognize and respect the personal dignity of the patient at all times. Rights, which may not be limited, include being treated with respect and dignity. 2. On 03/05/18 at 2:57 PM, Surveyor #5 and a registered nurse (Staff #502) inspected the seclusion and restraint room on the second floor. The nurse stated that the room is also used when admitting new patients to the hospital. Staff #502 also stated it is the hospital's procedure to have them stand in view of the camera when doing the skin check. 3. On 03/13/18 at 10:30 AM, Surveyor #3 and the hospital educator (Staff #301) inspected the "quiet room" on the first floor of the hospital. Staff #301 stated that the hospital has two quiet rooms, one for each floor. Staff members take patients to the quiet room when they require seclusion or restraint monitoring. The quiet room has a video camera located in the corner of the room and is continuously monitored and electronically recorded. Staff #301 stated that new hospital patients are also taken here to have a skin check	L 320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	013134	A. BUILDING: _____ B. WING _____	03/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMOKEY POINT BEHAVIORAL HOSPITAL	3955 156TH ST NE MARYSVILLE, WA 98271

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 320	Continued From page 27 assessment performed as part of their admission. Surveyor #3 asked Staff #301 how the hospital maintains patient privacy during continuous video recording. She stated that the patient is positioned near the front of the bed so that only their head is visible. The patient receives instruction to expose only one segment (e.g. an arm, a leg) of their body at a time. 4. On 03/14/18 at 2:50 PM, Surveyor #3 and Staff #301 reviewed a recording dated 03/14/18 at 7:50 PM of a patient being admitted to the hospital. The video recording showed a staff member as they escorted a young adolescent female patient in a hospital gown into the quiet room for the skin check assessment. During the video review, the surveyor observed the following: a. The patient points to the open door and requests for it to be closed. b. The hospital staff member (Staff #303) closed the door. c. The patient points to the video camera located in the corner of the quiet room. The patient's facial expression is consistent with a person experiencing anxiety and nervousness. d. During the skin check assessment process, the patient's breasts, buttocks, and groin area were clearly visible and not blocked from the view of the video camera at any time. 5. Immediately following the review of the video recording, Surveyor #3 interviewed the hospital educator (Staff #301) about the observed skin check process. Staff #301 stated that the skin check "did not happen how we are supposed to	L 320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	013134	A. BUILDING: _____ B. WING _____	03/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMOKEY POINT BEHAVIORAL HOSPITAL	3955 156TH ST NE MARYSVILLE, WA 98271

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 320	Continued From page 28 do this." When the surveyor asked why the skin checks do not occur on the nursing unit, she stated that there is no exam room on the unit and the hospital prefers not to perform skin checks in the patient's room. . Item #2- Medicare Patients Receive "Important Message for Medicare" Based on interview, record review, and review of hospital policies and procedures, the psychiatric hospital failed to ensure that Medicare patients received notification of their right to appeal their discharge to a designated Quality Improvement Organization, as demonstrated by 5 of 5 patients reviewed (Patients #906, #908, #912, #913, and #914). Failure to notify patients of their rights to appeal their discharge leads to infringement on patient rights and possible poor patient outcomes. Reference: 42 CFR 405.1205(b) - "Hospitals must provide each Medicare beneficiary who is an inpatient a standardized notice, the "Important Message from Medicare", within two days of their admission and again within two calendar days before discharge.. . . The hospital must establish and implement policies and procedures that effectively ensure that patients and/or their representatives have the information necessary to exercise their rights." Findings included: 1. On 03/15/18 at 2:00 PM, the Quality Manager (Staff #901) stated that the hospital did not have a policy regarding when the patients would be given the standardized notice, "Important	L 320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	013134	A. BUILDING: _____ B. WING _____	03/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMOKEY POINT BEHAVIORAL HOSPITAL	3955 156TH ST NE MARYSVILLE, WA 98271

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 320	Continued From page 29 Message for Medicare" as required with 42 CFR 405.1205 (b). 2. Surveyor #9 reviewed the medical records of five patients who had been discharge prior to the date of the review on 03/14/18. Four of the records reviewed showed that patients (Patients #906, #908, #912, #913) had received the initial "Important Message from Medicare" upon admission but did not receive a second notice prior to discharge. Review of Patient #914's record revealed that the patient received the "Important Message from Medicare" upon admission and again on the day of discharge but not 2 days prior to discharge as required.	L 320		
L 340	322-035.1H PROCEDURES-BEHAVIOR WAC 246-322-035 Policies and Procedures. (1) The licensee shall develop and implement the following written policies and procedures consistent with this chapter and services provided: (h) Managing assaultive, self-destructive, or out-of-control behavior, including: (i) Immediate actions and conduct; (ii) Use of seclusion and restraints consistent with WAC 246-322-180 and other applicable state standards; (iii) Documenting in the clinical record; This Washington Administrative Code is not met as evidenced by: . Based on observation, interview, and review of hospital documents, the hospital failed to develop and implement effective policies, procedures, and interventions to protect patients from assault and	L 340		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	013134	A. BUILDING: _____ B. WING _____	03/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMOKEY POINT BEHAVIORAL HOSPITAL	3955 156TH ST NE MARYSVILLE, WA 98271

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 340	Continued From page 30 abuse in two occurrences involving four patients (Patient #522, #523, #524, #915). Failure to ensure effective processes are in place to protect patients from abuse and assault risks serious harm to patients due to physical and psychological injury. Findings included: 1. Document review of the hospital's policy and procedure titled, "Precautions: Assault/Homicidal Risk," effective date: 05/17, showed that any patient who, because of previous history, or any other reason in the opinion of the physician, is regarded as potentially assaultive and/or homicidal may be placed on assault precautions. The policy stated that: -The patient is to be placed on unit restriction and monitored every 15 minutes -Staff will notify other unit staff and the Activity therapist that the patient is on Assault/Homicidal Risk Precautions -A sticker labeled "Assault/Homicidal Precautions" is placed on the front of the chart -A safety plan is placed in the master treatment plan -The unit staff will complete and route the "Restriction from Rights" form However, the policy failed to identify measures/interventions to prevent patient-to-patient assaults and failed to address measures/interventions for assaults between roommates. 2. On 03/06/18 at 9:00 AM, Surveyor #11 interviewed a provider (Staff #514) regarding an occurrence of sexual relations between two	L 340		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	013134	A. BUILDING: _____ B. WING _____	03/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMOKEY POINT BEHAVIORAL HOSPITAL	3955 156TH ST NE MARYSVILLE, WA 98271

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 340	Continued From page 31 patients (Patients #523 and #524). Staff #514 stated that Patient #523 had sex with a developmentally disabled adult with the cognitive abilities of a ten-year-old child (Patient #524). She stated the patient was a predatory sociopath who took phone numbers from vulnerable patients. Staff #514 stated that the facility had no system where they could stage or classify patients before placement. 3. On 03/07/18 Surveyor #5 reviewed the medical record of Patient #524, a developmentally delayed female who was admitted on 02/04/18 for the treatment of Bipolar I with psychotic features with a history of persistent delusions of having a "spiritual baby", sexually inappropriate behaviors, and jumping out of a moving car. The review of the medical record showed the following: On 02/12/18 at 2:20 PM, a Psychiatric progress note shows that the patient "..remains gravely disabled and high risk for victimization/running away in community and requires further treatment." On 02/13/18 at 9:40 AM, a Psychiatric progress note shows that hospital staff found the patient overnight having sexual intercourse with a patient. The report stated that Patient #524 entered Patient #523's room and propositioned intercourse. The note stated that the patient will remain on sexually inappropriate behavior precautions. On 02/13/18 at 11:30 AM, a note by a Mental Health Professional stated, "Spoke to (Patient #524) and asked her to talk about what had happened between her and a male patient last night. She stated, 'we had sex in my bathroom and in his bathroom.' The writer asked if the sex	L 340		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	013134	A. BUILDING: _____ B. WING _____	03/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMOKEY POINT BEHAVIORAL HOSPITAL	3955 156TH ST NE MARYSVILLE, WA 98271

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 340	Continued From page 32 was consensual and (the patient) replied "yes.' She said, 'he was sent by God to have babies with me. I can tell by his face. He has the face of the person sent by God." 4. On 03/13/18, Surveyor #5 reviewed the medical record of Patient #523 who staff members found having sexual intercourse with Patient #524. The medical record review showed that Patient #523 was admitted on 02/04/18 for the treatment of auditory voices telling him to kill himself, attempted suicide, and a history of schizoaffective disorder. The review of the medical record showed the following: On 02/04/18 at 6:25 AM, the admitting provider wrote orders for unit restrictions for 24 hours and close observation with 15-minute checks. The provider did not order assault/homicidal precautions or suicide precautions. On 02/12/18 at 11:37 PM, a nurse wrote a nursing order for sexual aggression precautions that required the patient to maintain 5-feet of distance from all female patients. Surveyor #5 found no evidence that the hospital initiated interventions to protect other patients from abuse prior to the encounter. 5. On 03/14/18 at 9:45 AM, Surveyor #5 and a Registered Nurse (Staff #513) reviewed the medical record of Patient #522 who was admitted on 02/11/18 for the treatment of Schizophrenia, audio and visual hallucinations and paranoid delusions. The review of the medical record showed the following: On 02/11/18 at 5:10 AM, a provider wrote an order to place the patient on assault/homicidal	L 340		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	013134	A. BUILDING: _____ B. WING _____	03/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMOKEY POINT BEHAVIORAL HOSPITAL	3955 156TH ST NE MARYSVILLE, WA 98271

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 340	Continued From page 33 precautions with close observation and 15-minute checks. On 02/17/18 at 3:30 AM, a Registered Nurse progress note showed that the patient was agitated because she did not like her roommate (Patient #915). The patient assaulted her roommate at 2:00 AM and again at 2:30 AM by pushing her. Patient #915 sustained a shoulder injury. Patient #915 was sleeping in the seclusion room to avoid sleeping in the room with Patient #522. Surveyor #5 found no evidence that staff moved Patient #522 to a different room after she assaulted her roommate. On 02/18/18 at 11:00 PM, a provider wrote an order for Patient #522 to be on Assault Precautions due to aggressive assault on staff. On 02/23/18 at 7:30 PM, a Registered Nurse progress note showed that the patient was threatening, verbalizing, and yelling at staff and patients and struck at and kicked another patient. On 02/24/18 at 5:06 AM, Registered Nurses' progress notes showed that Patient #522 was assaultive toward a patient and punched that patient in the jaw. Patient #522 was also assaultive toward staff and required physical restraint. Surveyor #5 found no evidence that staff members moved the patient to a different room after this assault. 6. At the time of the review, Surveyor #5 asked the Registered Nurse (Staff #513) what interventions staff members initiate to keep patients safe from other patients who are on Assault Precautions. Staff #513 stated, "It is just	L 340		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	013134	A. BUILDING: _____ B. WING _____	03/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMOKEY POINT BEHAVIORAL HOSPITAL	3955 156TH ST NE MARYSVILLE, WA 98271

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 340	Continued From page 34 an awareness, it means staff are aware." Surveyor #5 also asked Staff #513 if there was any increased monitoring of patients on Assault Precautions. Staff #513 stated that the "patients are on every 15 minute checks, which is the same for all patients." .	L 340		
L 350	322-035.1J POLICIES-INFECTION CONTROL WAC 246-322-035 Policies and Procedures. (1) The licensee shall develop and implement the following written policies and procedures consistent with this chapter and services provided: (j) Infection control as required by WAC 246-322-100; This Washington Administrative Code is not met as evidenced by: . Item #1- Prevention of water-borne illnesses Based on interview and record review, the hospital failed to implement and carry out components of its water management program. Failure to properly implement all components of the water management program risks patient infection from water-borne pathogens. Findings included: 1. Record review of the hospital policy titled, "Managing Biological Agents in Water Systems (AMME Plan)," Policy #EC.02.05.01.5, showed that hospital staff are required to develop a flow diagram to assess risks within the hospital water	L 350		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	013134	A. BUILDING: _____ B. WING _____	03/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMOKEY POINT BEHAVIORAL HOSPITAL	3955 156TH ST NE MARYSVILLE, WA 98271

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 350	Continued From page 35 system. The review also showed that hospital staff are required to document monitoring results for risk control methods and that the Assessment, Maintenance, Monitoring, and Evaluation (AMME) Committee is required to review the results quarterly. Record review of the hospital document titled, "AMME Monthly Monitoring Plan," showed that the hospital monitors the temperature of the domestic hot water storage, ice machine cleaning and maintenance, and eyewash station cleaning as risk control methods for the water management plan. Record review of the Environment of Care committee meeting minutes (dates: 05/30/17, 06/19/17, 07/20/17, 08/30/17, 09/27/17, 11/30/17, 12/12/17, and 01/09/18) did not show evidence that the monitoring results were reviewed as described in the hospital's "AMME Monthly Monitoring Plan". 2. On 03/12/18 at 4:10 PM, Surveyor #2 interviewed the Director of Plant Operations (Staff #201) and the Maintenance Technician (Staff #202) regarding the water management program. The surveyor asked the staff members if the hospital had developed a flow diagram of the hospital water system. The maintenance technician stated that a flow diagram had not been developed. The surveyor also asked if staff was monitoring and documenting the risk control methods listed in the water management policy. The technician stated that temperature monitoring of the water storage tanks was conducted visually, but temperatures were not recorded. Maintenance and inspection of the ice machines and eye wash stations was conducted and documented.	L 350		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	013134	A. BUILDING: _____ B. WING _____	03/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMOKEY POINT BEHAVIORAL HOSPITAL	3955 156TH ST NE MARYSVILLE, WA 98271

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 350	Continued From page 36 Item #2- Storage of Isolation Gowns Based on observation and interview, the hospital failed to store staff isolation gowns in a manner that prevented cross-contamination. Failure to protect personal protective equipment from contamination prior to use puts patients and staff at risk from infection. Findings included: 1. On 03/05/18 at at 1:50 PM, Surveyor #4 toured the 2nd floor units of the hospital. The tour included a soiled utility room (B-218). The observation showed isolation gowns and gloves stored on a wall unit inside the soiled utility room. 2. On 03/08/18 at 2:30 PM, Surveyor #4 interviewed the hospital's infection prevention nurse (Staff #404) about the above observation. She stated that isolation gowns should not be stored in the soiled utility room. The hospital provided gloves in the soiled utility room for housekeeping staff to use, but not isolation gowns.	L 350		
L 450	322-040.7 ADMIN-APPOINT STAFF WAC 246-322-040 Governing Body and Administration. The governing body shall: (7) Appoint and periodically reappoint the professional staff; This Washington Administrative Code is not met as evidenced by:	L 450		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	013134	A. BUILDING: _____ B. WING _____	03/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMOKEY POINT BEHAVIORAL HOSPITAL	3955 156TH ST NE MARYSVILLE, WA 98271

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 450	Continued From page 37 Based on interview and record review, the hospital failed to ensure that medical staff credentialing followed the Medical Staff Bylaws for appointment of practitioners. Failure to ensure that the hospital follows the Medical Staff Bylaws for the appointment process of providers puts patients at risk of substandard care and adverse outcomes. Findings included: 1. Document review of the hospital document titled, "Medical Staff Bylaws Smokey Point Behavioral Hospital," showed that in article 3.4, Terms of Appointment and Reappointment, initial and reappointments to the Medical Staff shall be made by the Board upon a recommendation from the MEC (Medical Executive Committee). Document review of the hospital document titled, "Governing Board Bylaws," approved on 04/17 showed that the Governing Board selects and appoints the CEO (Chief Executive Officer) who is accountable to the governing board for the recruitment of medical staff and the compliance with the Medical Staff Bylaws. Document review of the hospital's Governing Board Meeting Minutes dated 01/17/18, under the section titled, "Newly Credentialed Staff", showed the name of a physician, Susan Clark, MD. Document review of the hospital's "Application Verfifciation Worksheet 3.24.17" for the physician named above showed that there was no signature documenting review by the credentials committee, no checks indicating approval for appointment or requested privileges and there was no signature on the signature line for the	L 450		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	013134	A. BUILDING: _____ B. WING _____	03/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMOKEY POINT BEHAVIORAL HOSPITAL	3955 156TH ST NE MARYSVILLE, WA 98271

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 450	Continued From page 38 Medical Executive Committee Chairperson. 2. On 03/15/18 between 10:00 and 11:30 AM, the survey team interviewed members of the governing board. Surveyor #4 asked the governing board about the credentialing process and the lack of evidence for a functional Medical Executive Committee. The corporate Senior Vice President of Clinical Services (Staff #408) stated that the process needed "tightening up".	L 450		
L 485	322-040.8G ADMIN RULES-FUNCTIONS WAC 246-322-040 Governing Body and Administration. The governing body shall: (8) Require and approve professional staff bylaws and rules concerning, at a minimum: (g) Required functions; This Washington Administrative Code is not met as evidenced by: . Based on interview and review of Medical Staff Bylaws, and Medical Staff Rules and Regulations, the hospital's medical staff failed to carry out its functions consistent with the rules, regulations and bylaws approved by the governing body. Failure to adequately staff and structure the medical staff consistent with the policies and procedures approved by the governing body in the Medical Staff Bylaws, puts patients at risk of substandard care and adverse outcomes. Findings included: 1. Document review of the hospital's document titled," Medical Staff Bylaws Smokey Point Behavioral Hospital," (approved 05/30/17)	L 485		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	013134	A. BUILDING: _____ B. WING _____	03/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMOKEY POINT BEHAVIORAL HOSPITAL	3955 156TH ST NE MARYSVILLE, WA 98271

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 485	Continued From page 39	L 485		

showed that article 11.2 of the bylaws describes the composition of the Medical Executive Committee (MEC) as having a President, Vice-President, and Secretary-Treasurer, who are all active members of the medical staff, and will also include the Chief Executive Officer as an ex-officio member.

The duties of the MEC will include recommending to the board all manner of appointments, reappointments and staff membership, and will also account to the board and to the staff for the overall quality of care rendered to patients.

Staff functions to include: Quality Management, Credentials Review, Continuing Education, Bylaws, Rules and
Section 11.3 and 11.4 of the Medical Staff Bylaws showed that the MEC shall assign Regulations, Treatment Plan and Medical Record Review, Utilization Review, Pharmacy and Therapeutics, Infection Control, Risk Management and Patient Safety, Therapeutic Environment and Safety Function, Grievance Committee, and Practitioner Health. Provisions for staffing of these committee functions shall be either through staff assignment or through the MEC itself.

2. On 03/12/18 at 3:55 PM, Surveyor #4 interviewed the Medical Director (Staff #401) about the makeup of the Medical Executive Committee and how it functions at the hospital. She stated that there were not enough physicians to have a medical executive committee. At the time of the interview, there were 2 full time physicians including the Medical Director, 1 part-time physician and 1 locums physician.

3. On 03/15/18 between 10:00 and 11:30 AM, the survey team interviewed the hospital's governing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	013134	A. BUILDING: _____ B. WING _____	03/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMOKEY POINT BEHAVIORAL HOSPITAL	3955 156TH ST NE MARYSVILLE, WA 98271

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 485	Continued From page 40 body, including the hospital's Medical Director (Staff #401) about how the governing body receives information about patient safety and the overall operation of the hospital. Members of the governing body stated that their monitoring is multidimensional and includes review of all meeting minutes and that staff members make presentations at various times in the facility. Surveyor #4 asked if the governing body had evidence that the Medical Director directly interacted with the board regarding the medical care of patients. The board members indicated that there were discussions with the Medical Director, but there was no documentation in the minutes to reflect the topics or the scope of those discussions.	L 485		
L 490	322-040.8H ADMIN RULES-ACCOUNTABILITY WAC 246-322-040 Governing Body and Administration. The governing body shall: (8) Require and approve professional staff bylaws and rules concerning, at a minimum: (h) Accountability to the governing body; This Washington Administrative Code is not met as evidenced by: Based on interview and review of hospital documents, the hospital's governing body failed to ensure that it received periodic evaluations of the medical staff's quality of patient care services. Failure by the governing body to monitor and oversee the quality of medical services provided to the hospital's patient population puts patients at risk of substandard care and adverse	L 490		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	013134	A. BUILDING: _____ B. WING _____	03/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMOKEY POINT BEHAVIORAL HOSPITAL	3955 156TH ST NE MARYSVILLE, WA 98271

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 490	Continued From page 41 outcomes. Findings included: 1. Document review of the hospital's Medical Staff (Provider staff) meeting minutes for 05/30/17, 11/08/17, 11/17/17, 12/14/17, 01/17/18 and 01/31/18 showed that meeting minutes contained outlines of discussion topics, but failed to include committee decisions for each topic, action items for completion including assignments, and successive minutes contained no follow-up information from items put forward from the previous meeting. Document review of the Governing Board Meeting minutes for 01/17/18 (The only minutes provided to the surveyors by the hospital) showed that the following committees submitted meeting minutes to the Board for approval: Infection Control, Environment of Care/Safety, Performance Improvement/Executive Credentials, Medical Staff, Pharmacy and Therapeutics, and Grievance. Medical staff minutes approved by the Board consisted of 6 bulleted items without additional text, or action plans. 2. On 03/15/18 between 10:00 and 11:30 AM, the survey team interviewed the hospital's governing body, including the hospital's Medical Director (Staff #401) about how the governing body receives information about patient safety and the overall operation of the hospital. Members of the governing body stated that their monitoring is multidimensional and includes review of all meeting minutes and that staff members make presentations at various times in the facility. Surveyor #4 asked if the governing body had	L 490		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	013134	A. BUILDING: _____ B. WING _____	03/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMOKEY POINT BEHAVIORAL HOSPITAL	3955 156TH ST NE MARYSVILLE, WA 98271

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 490	Continued From page 42 evidence that the Medical Director directly interacted with the board regarding the medical care of patients. The board members indicated that there were discussions with the Medical Director, but there was no documentation in the minutes to reflect the topics or the scope of those discussions.	L 490		
L 495	322-040.8i ADMIN RULES-PERFORM EVALS WAC 246-322-040 Governing Body and Administration. The governing body shall: (8) Require and approve professional staff bylaws and rules concerning, at a minimum: (i) Mechanisms to monitor and evaluate quality of care and clinical performance; This Washington Administrative Code is not met as evidenced by: . Item #1- Physician Oversight Based on interview and document review, the hospital failed to provide oversight and periodic review of the medical staff as required in their Medical Staff Bylaws. Failure to periodically review the competency and practice of privileged practitioners puts patients at risk of harm from substandard care. Findings included: 1. Document review of the hospital document titled, "Medical Staff Bylaws," section 6.62, adopted 4/2017, showed that practitioners on provisional status shall be proctored by one or more appropriate members as determined by the	L 495		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	013134	A. BUILDING: _____ B. WING _____	03/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMOKEY POINT BEHAVIORAL HOSPITAL	3955 156TH ST NE MARYSVILLE, WA 98271

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 495	Continued From page 43 Medical Staff President for the number of cases or procedures specified by the Medical Staff President and that the proctor shall prepare a report with comments on the appointees performance. On 03/12/18 beginning at 3:55 PM, Surveyor #4 reviewed 10 provider credentialing files, including those of 4 mid-level providers. The review showed that 2 of the 4 mid-level providers, both Advanced Registered Nurse Practitioners (Staff #402 and Staff #403) appointed in October 2017, and were identified as being in provisional status. The surveyor found no evidence of completed practice reviews in their files. 2. On 3/12/18, at 3:55 PM, Surveyor #4 interviewed the acting Medical Director (Staff #401) about completion of practice reviews for provisional staff. The Medical Director stated that she was new to the position and had not completed any reviews to date. Item #2- Monitor Quality of Care (Data Collection and Analysis) Based on interview, and review of the hospital's quality program and quality documentation, the hospital failed to collect and analyze quality indicator data as part of the hospital's overall quality program. Failure to collect, aggregate and analyze data to improve patient outcomes puts patients at risk of substandard care. Findings included: 1. Document review of the hospital's Performance	L 495		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	013134	A. BUILDING: _____ B. WING _____	03/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMOKEY POINT BEHAVIORAL HOSPITAL	3955 156TH ST NE MARYSVILLE, WA 98271

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 495	Continued From page 44 Improvement Dashboard for 2017 showed the following: a. The hospital identified 138 hospital-wide indicators. Of these, indicators for utilization management, social services, radiology, cardiology, lab services, outpatient, medical outpatient, dietary, human resources, finance, discharge summaries, seclusion, fall risk, and ligature risk had no entries beyond September 2017. b. There was no data collection related to seclusion for 7 of 7 seclusion indicators. There was also no data collection after September 2017 related to restraint use for 6 of 7 restraint indicators. There was no data collection after September 2017 related to patient falls. 2. On 03/08/18, beginning at 1:30 PM, Surveyor #4 interviewed the hospital's Director for Performance Improvement & Risk (Staff #405) about the hospital's quality program data. The staff member stated that department directors are responsible for data submission to him, and acknowledged that there has been no consistent data collection since September, following his predecessor's departure. . Item #3-Monitor Quality of Care (Patient Safety) . Based on interview, record review, and review of the hospital's quality program and quality documentation, the hospital failed to perform root cause analyses after adverse patient events and failed to track adverse drug events and assaults as part of their process improvement plan for patient safety.	L 495		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	013134	A. BUILDING: _____ B. WING _____	03/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMOKEY POINT BEHAVIORAL HOSPITAL	3955 156TH ST NE MARYSVILLE, WA 98271

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 495	Continued From page 45 Failure to identify and analyze data to determine factors that contribute to patient injury can result in an unsafe healthcare environment. Findings included: 1. Document review of the hospital's policy titled, "Root Cause Analysis," (effective date 5/17) showed that the hospital defined "root cause analysis" as a process for identifying the basic or causal factors that underlies variation in performance including the occurrence or possible occurrence, of a sentinel event or "near miss", and defined "accident resulting in serious injury" as those serious physical injuries which result from accidents and which require a visit to an emergency room, medical center, or urgent care clinic and/or admission to a hospital. Document review of the hospital's policy titled, "Sentinel Event Reporting," (effective date 5/17) showed that sentinel event policy applies to events that meet criteria including suicide of a patient, even if the outcome was not death or permanent loss of function. Document review of the hospital's Pharmacy and Therapeutics Committee Meeting minutes (dated 09/26/17)showed that the Chief Nursing Officer (Staff #407) reviewed medication errors and presented a summary of key findings from a task force meeting held earlier in the day. The minutes stated, "The majority of errors are attributable to after hours/floor stock drugs." Document review of the hospital's Pharmacy and Therapeutics Committee Meeting minutes (dated 01/17/18) showed that the minutes reflected that the data presented by pharmacy on medication errors may not match the data collected by the	L 495		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	013134	A. BUILDING: _____ B. WING _____	03/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMOKEY POINT BEHAVIORAL HOSPITAL	3955 156TH ST NE MARYSVILLE, WA 98271

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 495	Continued From page 46 PI/Risk Director (Staff #405) for Q4, 2017, as pharmacy did not receive all the medication error reports. The minutes also stated the the PI/Risk Director will share the error reports through a weekly risk meeting. 2. On 03/08/15 at 10:48 AM, Surveyor #5 interviewed the Pharmacy Director (Staff #406) who stated that they started having weekly meetings to discuss the medication errors, but people didn't come so they haven't been occurring. She also stated currently there were no action plans or follow up on medication errors. 3. Surveyor #4 reviewed hospital incident reports filed between July 2017 and February 2018. During the months of December, January and February, the reports included the following incidents : a. A patient had a severe reaction to exposure to peanuts, requiring 2 doses of epinephrine and assistance from Emergency Medical Services b. In December, there were 4 of 5 patient-to-patient assaults that resulted in patient injury 4. During medical record review, Surveyor #5 identified 3 patients (#505, #506 and #508) with documented suicide attempts between January and February, 2018. One of 3 patients (#505) attempted suicide on two separate days during their admission (02/16/18 and 02/19/18). 5. On 03/08/17 beginning at 1:30 PM, Surveyor #4 interviewed the Director for Performance Improvement & Risk (Staff #405), regarding any root cause analyses that he completed related to any adverse patient events at the hospital. He	L 495		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	013134	A. BUILDING: _____ B. WING _____	03/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMOKEY POINT BEHAVIORAL HOSPITAL	3955 156TH ST NE MARYSVILLE, WA 98271

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 495	Continued From page 47 stated that there had been no root cause analyses completed to date, because there had been no identified sentinel events. 6. On 03/15/18 between 10:00 and 11:30 AM, the survey team interviewed the hospital's governing body about how they receive information about patient safety incidents. Board members stated that they receive information about assaults through the monthly operating report. 7. On 03/15/18 at 10:30 AM, The Director of Process Improvement and Risk (Staff #405) presented the survey team with a copy of the monthly operating report (MOR). The report showed the following: a. Data collection between June 2017 and January 2018 was only collected on total incidents b. The incident data was subdivided into Falls, Assault/Aggression, and Contraband, but only contained data for October 2017 through January 2018 c. Patient falls are included in the quality dashboard, but none of the data from the MOR appears in the current version of the quality dashboard d. Numbers for incidents, falls, assaults, and contraband are also expressed in rates per patient days and rates per 1000 patient days, but there is no evidence of analysis or tracking for trends. -At the time of the review, there was no evidence that data from the monthly operating report was integrated into the hospital's quality program.	L 495		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	013134	A. BUILDING: _____ B. WING _____	03/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMOKEY POINT BEHAVIORAL HOSPITAL	3955 156TH ST NE MARYSVILLE, WA 98271

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 495	Continued From page 48 Item #4- Monitor Quality of Care (Performance Improvement Projects) Based on interview, document review, and review of quality data, the hospital failed to develop and implement performance improvement activities that supported hospital quality indicators related to patient safety and quality of care and failed to develop action plans to address identified areas of concern. Failure to develop projects and action plans based on results of data collection and aimed at improving patient outcomes puts patients at risk from harm due to substandard care. Findings included: 1. Document review of the hospital's "Performance Improvement Dashboard" for 2017 showed the following: a. The number of reported medication transcription variances had increased from 12 in September 2017 to 60 in December 2017. b. The percentage of staff who demonstrate the correct method hand hygiene decreased from 94% in September 2017 to 54% in November 2017. Document review of the hospital's "Pharmacy and Therapeutics Committee" minutes from September 2017 showed that the Pharmacy department presented data on medication variances. The minutes included an action plan that stated that Pharmacy will continue to collect data on variances, adverse drug reactions and	L 495		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	013134	A. BUILDING: _____ B. WING _____	03/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMOKEY POINT BEHAVIORAL HOSPITAL	3955 156TH ST NE MARYSVILLE, WA 98271

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 495	Continued From page 49 quality improvement to present. 2. On 03/08/17 beginning at 1:30 PM, Surveyor #4 interviewed the Director of Performance Improvement and Risk (Staff #405), about any specific performance improvement projects related to the indicators. He was unable to identify any performance improvement projects tied to the indicators on the dashboard. 3. On 03/08/18 at 2:30 PM, Surveyor #4 asked the Infection Preventionist/Educator (Staff #404) about quality improvement projects related to hand hygiene. The staff member stated that there were no specific projects and that hand hygiene data collection continued to rely on in-person and video monitoring. 4. On 03/15/18 at 10:48 AM, Surveyor #5 interviewed the hospital Pharmacist (Staff #406). The staff member stated that she presents quarterly data to the Pharmacy and Therapeutics Committee, but that the data are not aggregated and there have been no action plans developed to address identified problems.	L 495		
L 505	322-050.1A PROVIDE PATIENT SERVICES WAC 246-322-050 Staff. The licensee shall: (1) Employ sufficient, qualified staff to: (a) Provide adequate patient services; This Washington Administrative Code is not met as evidenced by: . . Item #1- Nurse Staffing Based on document reviews and interviews, the	L 505		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	013134	A. BUILDING: _____ B. WING _____	03/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMOKEY POINT BEHAVIORAL HOSPITAL	3955 156TH ST NE MARYSVILLE, WA 98271

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 505	Continued From page 50 hospital failed to ensure the facility had sufficient nursing personnel to provide safe and effective care to patients. Failure to provide an adequate number of trained registered nurses (RN), licensed practical nurses (LPN), and mental health technicians (MHT) risks patient safety and delays in care and treatment. Findings included: 1. Document review of the hospital document titled, "Nurse Staffing Plan," dated 05/17, showed that nursing care is to be provided by sufficient numbers of nursing staff members including registered nurses and licensed practical nurses to meet the identified nursing care needs of patient and family members twenty-four hours a day. Core staffing is based on the following critical factors: - Patient characteristics - The number of patients receiving care, including admissions, discharges and transfers - Intensity of patient care being provided - The variability of patient care across the unit -The scope of services provided, accounting for architecture and geography of the unit -The staff characteristics, including staff consistency, tenure, experience - The number and competencies of both clinical and non-clinical support staff the nurse must collaborate or supervise. 2. On 03/14/18 at 2:40 PM, Surveyor #3 reviewed the hospital nurse-staffing grid that was approved by the chief nursing officer on 03/09/18. The nurse-staffing grid was organized by clinical unit and patient census. Unit staffing was divided into two types of personnel: "nurses" and mental	L 505		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	013134	A. BUILDING: _____ B. WING _____	03/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMOKEY POINT BEHAVIORAL HOSPITAL	3955 156TH ST NE MARYSVILLE, WA 98271

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 505	Continued From page 51 health technicians. The surveyor could not find any differentiation made on the staffing grid regarding the type of nurse required to staff the unit. The grid did not specify use of either a registered nurse or a licensed practical nurse. 3. A review of the daily staffing sheet utilized by the nursing supervisor for a seven-day period (01/28/18 - 02/03/18) revealed the following: a. The adolescent inpatient unit 1-East, which cares for children ages 12 to 17, did not have a registered nurse assigned to the night shift for 1 of 7 days reviewed. b. The adult geriatric unit 1-West, which cares for adults 55 and older did not have a registered nurse assigned to the night shift for 5 of 7 days, reviewed which included 4 consecutive nights. c. The adult unit 2-West which cares for adults 18 years and older with chronic mental illness did not have a registered nurse assigned to the day shift for 2 consecutive days and 1 of 7 night shifts. d. The adult unit 2-East which cares for adults 18 years and older with mood disorders did not have a registered nurse assigned to the night shift for 2 of 7 days reviewed. e. The adult unit 2-North which cares for adults 18 years and older with acute mental illnesses to include psychosis did not have any licensed nursing staff (either an RN or LPN) assigned for one night shift. The unit did not have a registered nurse assigned for 1 of 7 day shifts and 2 of 7 night shifts. 4. A review of the daily staffing sheet utilized by the nursing supervisor for three 3-day periods	L 505		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	013134	A. BUILDING: _____ B. WING _____	03/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMOKEY POINT BEHAVIORAL HOSPITAL	3955 156TH ST NE MARYSVILLE, WA 98271

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 505	Continued From page 52 (02/16/18 - 02/18/18; 02/17/18 - 03/01/18; 03/09/18 - 03/11/18) revealed the following: a. The adult geriatric unit 1-West, which cares for adults 55 and older did not have a registered nurse assigned to the night shift for 5 of 9 days reviewed, leaving the unit with a singular licensed practical nurse in attendance. In addition, the review showed that the unit had two 24-hour periods of the nine days analyzed in which no registered nurse was assigned. b. The adult unit 2-West which cares for adults 18 years and older with chronic mental illness did not have a registered nurse assigned to the unit for a 24-hour period. The review also showed two consecutive day shifts where no registered nurse was assigned. c. The adult unit 1-North, which cares for active duty military and veterans, did not have a registered nurse assigned for 6 out of 6 night shifts reviewed. d. The adult unit 2-North which cares for adults 18 years and older with acute mental illnesses to include psychosis, did not have a registered nurse assigned for a 36-hour consecutive period. 5. On 03/14/18 at 2:50 PM, Surveyor #3 interviewed Staff #301 about the daily staffing sheet utilized by the nursing supervisor. She verified and confirmed the findings described above. 6. On 03/06/18 at 2:25 PM, Surveyor #11 interviewed a physician (Staff #306) regarding staffing on the older adult unit 1-East. He stated that staffing on the floor is not adequate when there is only one nurse to eleven patients. Staff	L 505		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	013134	A. BUILDING: _____ B. WING _____	03/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMOKEY POINT BEHAVIORAL HOSPITAL	3955 156TH ST NE MARYSVILLE, WA 98271

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 505	Continued From page 53 #306 stated the nurse would have to do everything including rounding, administering medications, and addressing all of the patient needs. He indicated that when the acuity (intensity of need for care or monitoring) goes up, such as when patients require 1:1 monitoring, the hospital needs to increase the number of staff on the unit. 7. On 03/05/18 at 1:40 PM, Surveyor #5 interviewed the charge nurse (Staff #502) on 2-North about the unit and its patients. Staff #502 indicated he was a new nursing graduate and today was his first day off orientation. The surveyor asked Staff #502 if any of the patients were on special precautions such as line-of-sight monitoring or suicide precautions. He stated that he was unaware of any patient being on that status. A review of the patient charts on the unit revealed that two patients were on line-of-sight monitoring and one patient was on both fall and suicide precautions. The surveyor observed Staff #502 had difficulty navigating the medical record to locate requested documents. Staff #502 was unaware of which patients on the unit were there for involuntary treatment. 8. On 03/06/18 at 11:43 AM, Surveyor #5 interviewed a MHT (Staff #516) about her job duties. During the interview, Staff #516 stated that one of her roles is to lead groups. She also stated that because there is not enough staff, groups sometimes do not get done or she has to leave the group to do the 15-minute patient checks. Staff #516 stated because of this, she feels her groups are not as effective. 9. On 03/07/18 at 8:00 AM, Surveyor #11 interviewed a registered nurse (Staff #302) about staffing. The nurse stated that the nursing unit	L 505		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	013134	A. BUILDING: _____ B. WING _____	03/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMOKEY POINT BEHAVIORAL HOSPITAL	3955 156TH ST NE MARYSVILLE, WA 98271

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 505	Continued From page 54 2-East usually has 25 or more patients on it and is never staffed appropriately. She indicated that the hospital leadership never provides more than four staff members per shift even when there are patients who required one to one or line of sight monitoring. Staff #302 stated if there are only two staff members on a unit, it is very difficult to run the unit given all of the duties and responsibilities required of the staff to perform. She confirmed that this happens almost every day somewhere in the hospital with the night shift being very short staffed overall. 10. On 03/07/18 at 11:38 AM, Surveyor #5 interviewed a MHT (Staff #517) about her job duties. During the interview, Staff #517 stated that she has to run four groups during her shift. She stated that sometimes she has to stop group so she can go do her rounds on patients who do not participate. She acknowledged leaving intermittently affects the success of the group. 11. On 03/07/18 at 12:05 PM, Surveyor #5 interviewed a charge nurse (Staff #508) about maintaining a safe environment for patients. During the interview, Staff #508 stated that on 02/17/18 three patients tried to commit suicide on the unit 2-East. She stated that there was not enough staff to monitor the patients, and they were unable to find enough staff to come into work so they locked all the patients out of their rooms so they could be watched for their safety. 12. On 03/07/18 at 2:50 PM, Surveyor #11 interviewed the Chief Nursing Officer (CNO) (Staff #307) about nurse staffing for the hospital. He stated that he met last Thursday (03/01/18) with some nurses about their staffing concerns. Hospital leadership approved a staffing grid that included 5 more full time nursing positions. The	L 505		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	013134	A. BUILDING: _____ B. WING _____	03/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMOKEY POINT BEHAVIORAL HOSPITAL	3955 156TH ST NE MARYSVILLE, WA 98271

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 505	Continued From page 55 CNO stated that when the hospital was first opened, they were "rich" in staffing. By fall of last year, as time went by and the staff gained experience, corporate leadership asked him to be within budget. The CNO indicated that every nursing unit has a nurse that works every shift. He acknowledged there are more LPN's than RN's currently working. The CNO confirmed that there is no policy that delineates the roles and responsibilities of the RN versus the role and responsibilities of the LPN. 13. On 03/08/17 at 10:10 AM, Surveyors #4 and #5 presented to unit 2-West and asked the RN (Staff #512) standing at the nurse's station if they could speak with the charge nurse. The nurse became flustered and began looking through paperwork to determine which charge nurse was assigned to the unit for the day. When Staff #512 was unable to determine who the charge nurse was, she stated, "We have 2 nurses pick one." Surveyor #5 observed that Staff #512 was the only RN on the floor and the other nurse (Staff #518) was an LPN. 14. Review of the hospital grievance log between June 2017 and March 2018, showed that in December 2017, patients' family members or friends filed 10 grievances related to reduction of stated visitation hours. In five of those grievances, the complainants reported the hospital staff cited short staffing as the reason for curtailing patient visitation hours. Item #2- Physician on call Based on document review and interview, the hospital's governing body failed to ensure that a doctor of medicine or osteopathy was on call at	L 505		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	013134	A. BUILDING: _____ B. WING _____	03/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMOKEY POINT BEHAVIORAL HOSPITAL	3955 156TH ST NE MARYSVILLE, WA 98271

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 505	Continued From page 56 all times to provide onsite supervision of patient care . Failure to ensure that a privileged physician is on call at all times to provide supervision of mid-level providers and overall patient care puts patients at risk of harm from substandard care. Findings included: 1. Document review of the hospital's "on-call log" received from the Director of Performance Improvement and Risk (Staff #405)on 03/14/18, showed that from 01/29/18 to 03/31/18, a physician was only listed on call for 12-hour periods (8:00 AM to 8:00 PM) for the following dates: 01/29/18, 01/30/18, 02/05/18, 02/12/18, 02/19/18, 02/24/18, 02/26/18, 03/05/18, 03/12/18, 03/19/18, and 03/24/18. The remaining shifts show either no one listed for coverage, or mid-level provider (Advanced Registered Nurse Practitioner, Physician Assistant). Document review the hospital's "Medical Staff Policies and Procedure," effective date (4/17), showed that each month, the Medical Director will assure that a schedule identifying the psychiatrists and on-call dates is completed and distributed to all appropriate personnel. 2. On 03/15/18, between 10:00 and 11:30 AM, the surveyors interviewed the hospital's governing body. During the interview, Surveyor #4 asked the Medical Director (Staff #401) about how the hospital ensured there was 24- hour coverage of patients by a physician, when the call log did not reflect that staffing. She stated that she is always available, but there was no documentation or policy that described that process.	L 505		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	013134	A. BUILDING: _____ B. WING _____	03/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMOKEY POINT BEHAVIORAL HOSPITAL	3955 156TH ST NE MARYSVILLE, WA 98271

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L1055	322-170.2C EXAM & MEDICAL HISTORY WAC 246-322-170 Patient Care Services. (2) The licensee shall provide medical supervision and treatment, transfer, and discharge planning for each patient admitted or retained, including but not limited to: (c) A physical examination and medical history completed and recorded by a physician, advanced registered nurse practitioner, or physician assistant within twenty-four hours following admission, unless the patient had a physical examination and medical history completed within fourteen days prior to admission, and the information is recorded in the clinical record; This Washington Administrative Code is not met as evidenced by: Based on policy review and review of medical records, the hospital failed to ensure that medical providers completed and documented a History and Physical (H&P) for each patient within 24 hours after hospital admission. Failure to conduct an assessment on all patients at admission puts patients at risk of an adverse outcome in the event that the patient's medical condition require alteration of the treatment plan. Findings included: 1. Document review of the hospital's Medical Staff Rules and Regulations (04/17) showed that a H&P is to be completed within 24 hours of admission and if patient is a readmission and the H&P was performed within 30 days, then an	L1055		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	013134	A. BUILDING: _____ B. WING _____	03/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMOKEY POINT BEHAVIORAL HOSPITAL	3955 156TH ST NE MARYSVILLE, WA 98271

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L1055	Continued From page 58 update is needed. 2. Surveyor #9 reviewed the medical record of Patient # 908 who was admitted to the hospital on 02/17/18. The patient had been previously admitted to the hospital two weeks earlier. There was no H&P or update of an H&P from a previous admission included in the patient's record. ..	L1055		
L1065	322-170.2E TREATMENT PLAN-COMPREHENS WAC 246-322-170 Patient Care Services. (2) The licensee shall provide medical supervision and treatment, transfer, and discharge planning for each patient admitted or retained, including but not limited to: (e) A comprehensive treatment plan developed within seventy-two hours following admission: (i) Developed by a multi-disciplinary treatment team with input, when appropriate, by the patient, family, and other agencies; (ii) Reviewed and modified by a mental health professional as indicated by the patient's clinical condition; (iii) Interpreted to staff, patient, and, when possible and appropriate, to family; and (iv) Implemented by persons designated in the plan; This Washington Administrative Code is not met as evidenced by: . Item #1- Comprehensive Treatment Plans . Based on review of hospital policies and procedures and review of medical records, the	L1065		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	013134	A. BUILDING: _____ B. WING _____	03/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMOKEY POINT BEHAVIORAL HOSPITAL	3955 156TH ST NE MARYSVILLE, WA 98271

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L1065	Continued From page 59 hospital failed to ensure that staff developed, initiated, and updated patient care plans for 8 of 8 patients (Patient #906, #501, #504, #505, #522, #525, #526, and 1101). . Failure to develop care plans to address patient care may lead to patient harm and failure to appropriately treat a medical condition. . Findings included: 1. Document review of the hospital's policy titled, "Treatment Planning," effective 05/17, showed that the registered nurse (RN) should add any medical problems to be addressed in the treatment plan. Document review of the hospital's policy and procedure titled, "Medical Staff: Treatment Planning," effective date 04/17, showed that an initial plan of care will be documented within 24 hours of admission by the admitting nurse and focus on safety, diagnostics and patient centered goal setting. The multidisciplinary team will prepare the Master Treatment plan within 72 hours of admission and will establish goals in reference to specified problems. Document review of the hospital's policy and procedure titled, "Precaution: Suicide," effective date 05/07, showed that patients placed on suicide precautions must have a safety plan in the Master Treatment Plan. Document review of the hospital's policy and procedure titled, "Use of Seclusion," effective date 05/17, showed that patients placed in seclusion must have seclusion added to the Master Treatment Plan.	L1065		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	013134	A. BUILDING: _____ B. WING _____	03/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMOKEY POINT BEHAVIORAL HOSPITAL	3955 156TH ST NE MARYSVILLE, WA 98271

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L1065	Continued From page 60 Document review of the hospital's policy and procedure titled, "Use of Restraints," effective date 05/17, showed that the treatment plan for patients requiring restraint should be reviewed and amended following the first episode of restraint to include measures to prevent reoccurrence. Document review of the hospital's policy and procedure titled, "Precautions: Assault/Homicidal Risk," effective date 05/17, showed that patients placed on assault or homicide precautions must have a safety plan added to the Master Treatment Plan. Document review of the hospital's policy and procedure titled, "Fall Prevention Program Guidelines," effective date 05/17, showed that when patients are assessed at high risk for fall, the treatment plan will identify any and all individualized interventions to prevent falls. 2. Surveyor #9 reviewed the medical record of Patient #906, an insulin dependent diabetic admitted to the hospital on 02/26/18. A review of the nursing treatment plan revealed no planning related to diabetes treatment, including insulin dosing and blood glucose monitoring. 3. On 03/05/18 at 2:10 PM, Surveyor #5 reviewed the medical record of Patient #501 who was admitted on 02/24/18 for stabilization and treatment of continuing suicidal ideation (SI) with intention to harm herself. The patient's previous diagnosis included: -Bipolar disorder -Self-injurious behavior by cutting herself -Auditory hallucinations -A history of three suicide attempts	L1065		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	013134	A. BUILDING: _____ B. WING _____	03/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMOKEY POINT BEHAVIORAL HOSPITAL	3955 156TH ST NE MARYSVILLE, WA 98271

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L1065	Continued From page 61 -An attempt to choke herself on a previous admission to the hospital The medical record review showed the following: On 02/25/18 at 1:45 AM, the patient was assessed at high risk for suicide and placed on suicide precautions. Surveyor #5 found no evidence that staff had added safety precautions for suicide or self-harm to the Master Treatment Plan. On 03/03/18 at 4:40 PM, a nursing note showed that the patient assaulted multiple staff members and was moved to the 2-North unit. Surveyor #5 found no evidence that the Master Treatment Plan included a safety plan for assault precaution. On 03/03/18 at 5:30 PM, the daily nursing assessment for suicidal ideation documentation showed that "attempted" and "actively endorsed" were both circled in the suicide assessment. Surveyor #5 found no evidence that the Master Treatment Plan included a safety plan addendum for suicide precaution. 4. On 03/06/18, Survey #5 reviewed the discharge medical record of Patient #505 who was admitted on 02/10/18, following a suicide attempt made 24 hours prior to admission to the hospital. The medical record review showed the following: On 02/10/18 at 4:30 PM, an admitting provider wrote an order to place the patient on suicide precautions and self-harm precautions with close observation and 15-minute checks. Surveyor #5 found no evidence of a safety plan for suicide in the Master Treatment Plan.	L1065		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	013134	A. BUILDING: _____ B. WING _____	03/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMOKEY POINT BEHAVIORAL HOSPITAL	3955 156TH ST NE MARYSVILLE, WA 98271

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L1065	Continued From page 62 On 02/12/18 at 1:06 PM, a provider wrote an order to discontinue all unit restrictions. The patient observation record showed that the patient was removed from suicide precautions but remained on self-harm precautions and was checked every 15 minutes. Four days later, on 02/16/18, the patient attempted suicide by hanging himself with his bed sheets and was transported to an Emergency Department at a medical hospital. Surveyor #5 found no evidence that a safety plan was added to the Master Treatment Plan. On 02/19/18 at 11:30 AM, a nursing note showed that the patient made a second suicide attempt. The Hospital staff found the patient down with a blue blanket around his neck. Surveyor #5 found no evidence of a safety plan for suicide prevention in the Master Treatment Plan. 5. On 03/09/18 at 8:30 AM, Surveyor #5 reviewed the discharged medical record for Patient #525 who was admitted on 01/24/18 for the treatment of suicidal ideation that included a plan to kill himself. The medical record review showed the following: The Emergency Department provider notes dated 01/23/18 at 5:51 PM showed that the patient's medical history included: - Spina bifida (a spinal birth defect) -A neurogenic bladder (dysfunction of the urinary bladder due to disease of the central nervous system or peripheral nerves involved in the control of urination) -An elevated white blood cell count -A urinary tract infection -Wheelchair bound -Has an anaphylactic allergy to peanuts	L1065		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	013134	A. BUILDING: _____ B. WING _____	03/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMOKEY POINT BEHAVIORAL HOSPITAL	3955 156TH ST NE MARYSVILLE, WA 98271

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L1065	Continued From page 63 On 01/24/18 at 5:30 PM, the Initial Nursing Assessment showed that the patient had an anaphylactic allergy to peanut butter, was in a wheelchair, and had stiff knees. The patient was assessed at low risk for a fall, and independent for toileting. In the "Review of Systems" section of the assessment, hospital staff failed to complete and document assessment of the patient's gastrointestinal and genitourinary systems. On 01/25/18, the patient's Master Treatment plan showed two psychiatric problems including anxiety and depression. The Master Treatment Plan listed no medical problems. An update on 02/04/18 shows no changes to the treatment plan. Surveyor #5 found no evidence that the staff addressed medical problems including disability with lower extremity weakness affecting mobility and requiring a wheelchair, self-catheterization for neurogenic bladder, a bowel program, or an anaphylactic allergy to peanuts in the Master Treatment Plan. 6. On 03/12/18, Surveyor #5 reviewed the medical record of Patient #504, who was admitted on 02/06/18 for treatment of Psychosis, Suicidal Ideation, Command Auditory Hallucinations to harm self, Audio, Visual and Tactile Hallucinations, poor sleep and poor appetite. The medical record review showed the patient was a diabetic and taking metformin (a medication used to treat patients with Type 2 Diabetes). Surveyor #5 found no evidence that staff had addressed the patient's diabetes treatment, including metformin dosing and blood glucose monitoring, in the Master Treatment Plan. 7. On 03/13/18 at 1:58 PM, Surveyor #5 reviewed the medical record for Patient #526, who had	L1065		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	013134	A. BUILDING: _____ B. WING _____	03/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMOKEY POINT BEHAVIORAL HOSPITAL	3955 156TH ST NE MARYSVILLE, WA 98271

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L1065	Continued From page 64 been admitted on 03/12/18. The medical record review showed that the patient had fallen the night before and hit his head and was subsequently transferred to an Emergency Department at a medical hospital. Surveyor #5 found no evidence the treatment plan identified individualized interventions to prevent falls. At the time of the review, Surveyor #5 observed Patient #526 sitting halfway down in a chair with only regular socks on his feet. 8. On 03/14/18 at 9:45 AM, Surveyor #5 and a Registered Nurse (Staff #513) reviewed the medical record of Patient #522 who was admitted on 02/11/18 for the treatment of Schizophrenia, Audio and Visual Hallucinations and Paranoid Delusions. The record review showed the following: On 02/11/18 at 5:10 AM, a provider wrote an order to place the patient on assault/homicidal precautions with close observation and 15-minute checks. Surveyor #5 found no evidence that staff addressed a safety plan for assault/homicidal precautions in the Master Treatment Plan. On 02/17/18 at 3:30 AM, a Registered Nurse progress note showed that the patient was agitated because she did not like her roommate. The patient assaulted her roommate by pushing her on two occasions, first at 2:00 AM, and again at 2:30 AM. Surveyor #5 found no evidence that staff addressed a safety plan for assault/homicidal precautions in the Master Treatment Plan. On 02/18/18 at 11:00 PM, a provider wrote an order for the patient to be on Assault Precautions due to aggressive assault on staff. Surveyor #5	L1065		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	013134	A. BUILDING: _____ B. WING _____	03/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMOKEY POINT BEHAVIORAL HOSPITAL	3955 156TH ST NE MARYSVILLE, WA 98271

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L1065	Continued From page 65 found no evidence that staff included or updated the Master Treatment Plan to include a safety plan. On 02/19/18 at 6:00 AM, a Registered Nurse progress note showed that the patient was verbally aggressive, threatening patients and staff, and assaultive toward staff. Staff placed the patient in seclusion and gave the patient medications. Surveyor #5 found no evidence that staff added the patient's seclusion to the Master Treatment Plan. On 02/21/18, 02/24/18, and 02/25/18, the patient demonstrated continued assaultive behavior on staff and peers. Surveyor #5 found no evidence that staff added a safety plan for assault/homicidal precautions to the Master Treatment Plan. 9. On 01/26/18 at 11:00 PM, Patient #1101 was readmitted to the psychiatric hospital for psychiatric care following discharge from a medical center where the patient received care for cellulitis and diabetic ulcers on the right great toe and 2nd toe. The Master Treatment Plan showed that the patient's active medical problem list included diabetes and hypertension but did not include the patient's diagnoses of cellulitis [skin infection] and diabetic ulcers on his toes. There was no nursing care plan in the patient's medical record to guide nursing staff in the care of a patient with a wound. Review of the patient's discharge medical record showed the following: The Nursing Initial Assessment completed on 01/26/18 at 11:00 PM, stated that the right second toe was an open wound and that it was red and swollen with a dressing cover. The nurse documented that the patient had right foot pain.	L1065		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	013134	A. BUILDING: _____ B. WING _____	03/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMOKEY POINT BEHAVIORAL HOSPITAL	3955 156TH ST NE MARYSVILLE, WA 98271

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L1065	Continued From page 66 On 01/27/18 at 8:30 AM, a medical consultant (Staff #1105) completed the patient's history and physical. The history and physical examination showed that the patient had cellulitis and a diabetic foot ulcer. On 03/09/18 at 10:00 AM, Surveyor #11 interviewed the Chief Nursing Officer (Staff #1102) about the Master Treatment Plan and Problem List for Patient #1101. The Chief Nursing Officer acknowledged that the Master Treatment Plan did not include the patient's wound or cellulitis and that there was no nursing care plan in the patient's medical record. ITEM #2- Nutritional Screen Based on review of hospital policies and procedure and review of medical records, the hospital failed to ensure that staff referred a patient for a nutritional consult with a dietician for evaluation of nutritional deficiencies. Failure to refer a patient for a nutritional consult may lead to poor nutrition and poor health outcomes. Findings included: 1. Document review of the hospital's form titled, "Nutritional Screen," showed that patients were to receive a referral for a nutritional consult when any of the referenced conditions were identified in a patient's screening. This included: -Poor appetite -Diabetes -Underweight	L1065		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	013134	A. BUILDING: _____ B. WING _____	03/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMOKEY POINT BEHAVIORAL HOSPITAL	3955 156TH ST NE MARYSVILLE, WA 98271

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L1065	Continued From page 67 -Chronic constipation -Medical condition that requires nutritional intervention -On medications that may interact with foods -Taking nutritional supplements at home -Lactose intolerant -Pregnant-History of eating disorder -Obese -Signs of malnutrition Unplanned weight gain or loss -Chewing, swallowing problems -History of chronic dieting -Nausea and vomiting more than 3 days . 2. Surveyor #9 reviewed the medical record of patient #911, whose nutritional screening showed that the patient had a poor appetite and was taking nutritional supplements at home; however, there was no evidence in the patient's record that staff requested a nutritional consult. 3. On 03/12/18, Surveyor #5 reviewed the medical record of Patient #504 who was admitted on 02/06/18 for treatment of Psychosis, Suicidal Ideation, Command Auditory Hallucinations to harm self, Audio, Visual and Tactile Hallucinations, poor sleep and poor appetite. The medical record review showed the patient was a diabetic and taking metformin (a medication used to treat patients with Type 2 Diabetes). The patient's nutritional screen on admission showed the patient is a Diabetic, which required a referral for a Nutrition consult. Surveyor #5 found no evidence staff requested a Nutritional consult for the patient. .	L1065		
L1090	322-170.2J REFERRALS	L1090		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	013134	A. BUILDING: _____ B. WING _____	03/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMOKEY POINT BEHAVIORAL HOSPITAL	3955 156TH ST NE MARYSVILLE, WA 98271

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L1090	Continued From page 68 WAC 246-322-170 Patient Care Services. (2) The licensee shall provide medical supervision and treatment, transfer, and discharge planning for each patient admitted or retained, including but not limited to: (j) Referrals to appropriate resources and community services during and after hospitalization. This Washington Administrative Code is not met as evidenced by: Based on interview, document review and medical record review, the hospital failed to refer patients for appropriate medical care during their hospitalization. Failure to provide patients with needed medical services outside the scope of the psychiatric hospital puts patients at risk of injury or death. On 01/26/18 at 11:00 PM, Patient #1101 was readmitted to the psychiatric hospital for psychiatric care following discharge from a medical center where the patient received care for cellulitis and diabetic ulcers on the right great toe and 2nd toe. Review of the patient's discharged medical record showed the following: On 01/27/18 at 8:30 AM, a medical consultant (Staff #1105) completed the patient's history and physical. The history and physical examination showed that the patient had cellulitis and a diabetic foot ulcer. The medical consultant referred the patient for wound care and stated that the patient was medically stable for psychiatric treatment unless the wound worsens. The physician's order in the patient's medical record showed the medical consultant (Staff	L1090		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	013134	A. BUILDING: _____ B. WING _____	03/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMOKEY POINT BEHAVIORAL HOSPITAL	3955 156TH ST NE MARYSVILLE, WA 98271

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L1090	Continued From page 69 #1105) wrote an order on 01/27/18 at 8:40 AM referring the patient to a wound care clinic as soon as possible, to evaluate and treat the wound. The medical consultant's documentation dated 01/30/18 at 8:30 PM showed that the patient's diabetic foot ulcer was worsening. The medical consultant again recommended the hospital staff consult wound care. The medical consultant's documentation dated 02/02/18 at 8:45 AM showed that the patient had an open wound on the second toe of the right foot. The consultant stated that the toe needed debridement (removal of damaged tissue) and the hospital staff should follow through with the wound care referral. There was no evidence in the medical record to show that the hospital had referred the patient to a wound care clinic for treatment of the diabetic ulcers. Document review of the form titled, "Memorandum of Transfer," showed the hospital transferred Patient #1101 to a medical center on 02/05/18 at 2:55 PM for treatment of the diabetic foot ulcers. On 03/07/18 at 5:00 PM, Surveyor #11 interviewed a registered nurse (Staff #1101) about the referral to the wound care clinic for Patient #1101. The registered nurse confirmed that the hospital did not send the patient to a wound care clinic. On 03/09/18 at 10:00 AM, Surveyor #11 reviewed the patient's medical record with the Chief Nursing Officer (Staff #1102). The Chief Nursing	L1090		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	013134	A. BUILDING: _____ B. WING _____	03/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMOKEY POINT BEHAVIORAL HOSPITAL	3955 156TH ST NE MARYSVILLE, WA 98271

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L1090	Continued From page 70 Officer confirmed that there was no documentation in the patient's medical record indicating that the hospital referred the patient to a wound care clinic. When the surveyor asked Staff #1102 about Patient #1101's missed medical referral, the Chief Nursing Officer stated that the registered nurse that transcribed the order was responsible for making the referral. On 03/13/18 at 3:15 PM, the Discharge Summary completed by the provider (Staff #1106) showed that the hospital transferred Patient #1101 to the emergency department at the medical center for treatment of worsening toe infection and worsening levels of pain. On 03/14/18 at 11:15 AM, Surveyor #11 interviewed a registered nurse (Staff #1103) about the process for referring Patient #1101 to the wound clinic. The registered nurse stated that at the time the order was noted by Staff #1103, a medical consultant (Staff #1105) and a nurse practitioner (Staff #1104) were there discussing the patient. The nurse stated that he thought the Nurse Practitioner would refer the patient to the wound clinic. The nurse found out later that referrals like this should be brought to the attention of the nurse manager. Staff #1103 stated that he has not received training on the hospital's process for referring patients to outside facilities.	L1090		
L1105	322-170.3C NURSING SERVICES WAC 246-322-170 Patient Care Services. (3) The licensee shall provide, or arrange for, diagnostic and therapeutic services prescribed by the attending professional staff,	L1105		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	013134	A. BUILDING: _____ B. WING _____	03/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMOKEY POINT BEHAVIORAL HOSPITAL	3955 156TH ST NE MARYSVILLE, WA 98271

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L1105	Continued From page 71 including: (c) Nursing services, including: (i) A psychiatric nurse, employed full time, responsible for directing nursing services twenty-four hours per day; and (ii) One or more registered nurses on duty within the hospital at all times to supervise nursing care; This Washington Administrative Code is not met as evidenced by: . Based on patient record review and review of the hospital's policy and procedures, the hospital failed to ensure that a registered nurse (RN) signed off on an initial nursing assessment and treatment plan completed by a Licensed Practical Nurse (LPN). . Failure of the RN to review an initial assessment and treatment plan could lead to patient harm if physical or psychological conditions are not identified. . Findings included: . 1. The hospital's policy and procedure titled, "Treatment Planning," effective 05/17, showed that the RN will add any medical problems to be addressed to the treatment plan and discussed with the patient/family and any emergency precautions will be included in the initial treatment plan. . 2. Surveyor #9 reviewed the medical records of patient #907 which showed that the initial nursing assessment and initial treatment plan was conducted by and signed off by a LPN. The RN did not co-sign the initial nursing assessment or the initial treatment plan.	L1105		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	013134	A. BUILDING: _____ B. WING _____	03/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMOKEY POINT BEHAVIORAL HOSPITAL	3955 156TH ST NE MARYSVILLE, WA 98271

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L1120	Continued From page 72	L1120		
L1120	322-170.3F OT SERVICES WAC 246-322-170 Patient Care Services. (3) The licensee shall provide, or arrange for, diagnostic and therapeutic services prescribed by the attending professional staff, including: (f) Occupational therapy services coordinated and supervised by an occupational therapist with experience working with psychiatric patients, responsible for integrating occupational therapy functions into the patient's comprehensive treatment plan; This Washington Administrative Code is not met as evidenced by: . Based on interview and record review, the hospital failed to provide Occupational Therapy Services in a timely manner when physicians ordered evaluations for 5 of 8 patients (Patients #1102, #1103, #1104, #1105, and #1106). Failure to provide Occupational Therapy Services in a timely manner places patients at risk for decreased function and potential loss of independence upon discharge. Findings included: 1. Review of the medical record of seven current hospital patients and one discharged patient for timeliness of occupational therapy evaluations showed the following: a. Patient #1102 was a 62 year-old admitted to the hospital on 02/21/18 for treatment of delusional thoughts, depression, and anxiety.	L1120		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	013134	A. BUILDING: _____ B. WING _____	03/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMOKEY POINT BEHAVIORAL HOSPITAL	3955 156TH ST NE MARYSVILLE, WA 98271

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L1120	Continued From page 73 Review of the patient's medical record showed that on 02/22/18 at 10:00 AM the patient's provider ordered occupational therapy to assess the patient for cognitive decline and to perform a functional assessment. Hospital staff transferred the patient to a medical center on 3/1/18. There was no occupational therapy consult in the medical record b. Patient #1103 was a 65 year-old admitted to the hospital on 01/24/18. Review of the patient's medical record showed that the patient's provider ordered an occupational therapy evaluation on 02/02/18. An Occupational Therapist evaluated the patient on 02/12/18; ten days after the initial order. c. Patient #1104 was a 73 year-old admitted to the hospital on 02/21/18. The patient's provider ordered an occupational therapy evaluation on 02/24/18. An Occupational Therapist evaluated the patient on 03/12/18; nineteen days after the initial order. d. Patient #1105 was a 52 year-old admitted to the hospital on 01/04/18. The patient's provider ordered an occupational therapy evaluation on 02/19/18. Review of the medical record showed that the Occupational Therapist initially saw the patient on 02/19/18 but the evaluation was not completed until 03/12/18; twenty-eight days after the initial order. e. Patient #1106 was a 74-year-old patient admitted to the hospital on 11/29/17. The patient's provider ordered an occupational therapy evaluation on 01/17/18. Review of the patient's medical record showed that the Occupational Therapist evaluated the patient on 02/12/18; twenty-three days after the initial order.	L1120		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	013134	A. BUILDING: _____ B. WING _____	03/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMOKEY POINT BEHAVIORAL HOSPITAL	3955 156TH ST NE MARYSVILLE, WA 98271

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L1120	Continued From page 74 2. On 03/06/18 at 2:25 PM, Surveyor #11 interviewed a provider (Staff #1101) who provides psychiatric care for patients admitted to the Older Adult Unit (1-West). The provider stated that there was only one Occupational Therapist and they are only at the facility one day per week. 3. On 03/14/18 at 3:30 PM, Surveyor #11 interviewed a Recreational Therapist (Staff #1107) about Occupational Therapy Services. The Recreational Therapist stated that there was only one Occupational Therapist and that they are only at the facility on Mondays. She stated that the Occupational Therapist had been out of the office due to illness. Staff #1107 stated that the hospital needed more occupational therapy hours to meet patient needs. 4. On 03/14/18 at 3:40 PM, Surveyor #11 interviewed the Director of Clinical Services (Staff #1108) about availability of Occupational Therapy Services. The Director of Clinical Services confirmed that the Occupational Therapist was only available on Mondays and had limited ability to perform evaluations on any other day of the week. Staff #1108 left the room then returned after speaking with the Chief Executive Officer (Staff #1109). Staff #1108 reported that the Chief Executive Officer told her that the hospital had a contract for Occupational Therapy, Physical Therapy, and Speech Therapy. The Director of Clinical Services stated she did not know about the availability of contracted services prior to the conversation with the Chief Executive Officer. Staff #1108 stated that hospital staff had not utilized the contracted services because hospital administration made the decision to use an Occupational Therapist on an as needed basis instead.	L1120		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	013134	A. BUILDING: _____ B. WING _____	03/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMOKEY POINT BEHAVIORAL HOSPITAL	3955 156TH ST NE MARYSVILLE, WA 98271

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L1120	Continued From page 75	L1120		
L1145	322-180.1C RESTRAINT OBSERVATIONS WAC 246-322-180 Patient Safety and Seclusion Care. (1) The licensee shall assure seclusion and restraint are used only to the extent and duration necessary to ensure the safety of patients, staff, and property, as follows: (c) Staff shall observe any patient in restraint or seclusion at least every fifteen minutes, intervening as necessary, and recording observations and interventions in the clinical record; This Washington Administrative Code is not met as evidenced by: . Item #1- Updating the Treatment Plan . Based on policy review and review of patient records, the hospital failed to modify the patients' plan of care after placing patients in restraints. Failure to modify care plans when patients are in restraints, placed patients at risk of harm by not meeting physical and emotional needs. Findings included: 1. Document review of the hospital policy titled, "Use of Restraints," effective 05/17, showed that as part of documentation requirements, if restraint or seclusion are used it should be added to the "Master Treatment Plan." 2. Surveyor #9 reviewed the records of 5 patients	L1145		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	013134	A. BUILDING: _____ B. WING _____	03/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMOKEY POINT BEHAVIORAL HOSPITAL	3955 156TH ST NE MARYSVILLE, WA 98271

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L1145	Continued From page 76 who were placed in restraints (Patients #901, #902, #903, #904, #905). Five of five records did not have an updated treatment plan to reflect the patient being placed in restraints as per hospital policy. 3. On 03/13/18, Surveyor #5 reviewed the medical record of Patient #527 who was admitted on 10/06/17 for the treatment of psychosis, and suicidal ideation. The record review showed 24 episodes of restraint between 10/10/17 and 11/13/17. Review of the treatment plan showed that the treatment plan was never updated to reflect the patient being placed in restraints per hospital policy. - On 03/13/18 at 9:40 AM, the Chief Nursing Officer (Staff #501) confirmed the finding. 4. On 03/14/18, Surveyor #5 reviewed the medical record for Patient #522 who was admitted on 02/11/18 for the treatment of Schizophrenia, Audio and Visual Hallucinations and Paranoid Delusions. The record review showed seven episodes of restraint or seclusion from 02/18/18 to 02/23/18. Review of the treatment plan showed that the treatment plan was never updated to reflect the patient being placed in restraints per hospital policy. -At the time of the record review, a Registered Nurse (Staff #513) confirmed the finding. . Item #2- Failure to Follow Policy Regarding Restraint Documentation . Based on record review and review of the hospital's policies and procedures, the hospital failed to ensure that staff members followed the	L1145		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	013134	A. BUILDING: _____ B. WING _____	03/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMOKEY POINT BEHAVIORAL HOSPITAL	3955 156TH ST NE MARYSVILLE, WA 98271

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L1145	Continued From page 77 hospital's restraint policy and procedure for 7 of 7 records reviewed (Patients #522, #527, #901, #902, #903, #904, and #905). . Failure to follow established policies and procedures places patients at risk of physical and psychological harm and possible violation of patient rights. . Findings included: 1. Document review of the hospital's policy titled,"Use of Restraints," effective 05/17, showed that documentation requirements included patient's response to the intervention, medications given, patient monitoring, fluids and meals offered, personal hygiene needs met, information given to patient regarding behavior required for removal, documentation of patient and staff and patient debriefing following the use of restraints. 2. Surveyor #9 reviewed the medical records of five patients placed in restraints. Four of the five patients (Patients #901, #902, #903, #904) did not have complete documentation per hospital policy. Restraint/Seclusion documentation includes the following: Part 1-Criteria for Seclusion/Restraint use and Criteria for release for Seclusion/Restraint, type of restraint used and less restrictive measure attempted. Part II- One hour face to face evaluation, MD progress note and validation order Part III- Patient debriefing Part IV- Restraint/Seclusion -Continuous 1:1	L1145		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	013134	A. BUILDING: _____ B. WING _____	03/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMOKEY POINT BEHAVIORAL HOSPITAL	3955 156TH ST NE MARYSVILLE, WA 98271

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L1145	Continued From page 78 monitoring. The records were missing parts I, II, III and IV of the Restraint/Seclusion documentation as required by the hospital policy. 3. Surveyor #9 reviewed the medical record of Patient #905. The face-to-face physician progress note and validation of the order was not signed and dated by the provider who evaluated the patient. 4. On 03/13/18, Surveyor #5 reviewed the medical record of Patient #527 who was admitted on 10/06/17 for the treatment of psychosis, and suicidal ideation. The record review showed 24 episodes of restraint from 10/10/17 and 11/13/17. The reviewed showed that 14 of the 24 of the episodes were missing sections I, II, III and IV of the Restraint/Seclusion documentation as required by the hospital policy and 3 of the 24 episodes were missing parts III and IV of the Restraint/Seclusion documentation as required by the hospital policy. -On 03/13/18 at 9:40 AM, the Chief Nursing Officer (Staff #501) verified the findings and stated that sections I-IV should be completed for each episode of restraint. 5. On 03/14/18, Surveyor #5 reviewed the medical record for Patient #522 who was admitted on 02/11/18 for the treatment of Schizophrenia, Audio and Visual Hallucinations and Paranoid Delusions. The record review showed seven episodes of restraint or seclusion from 02/18/18 to 02/23/18. The review showed that one of seven episodes was missing sections I, II, III and IV of the Restraint/Seclusion documentation as required by the hospital policy	L1145		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	013134	A. BUILDING: _____ B. WING _____	03/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMOKEY POINT BEHAVIORAL HOSPITAL	3955 156TH ST NE MARYSVILLE, WA 98271

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L1145	Continued From page 79 and one of seven was missing sections II, III and IV of the Restraint/Seclusion documentation as required by the hospital policy. -On 03/13/18 at 9:35 AM, a Registered Nurse (Staff #513) verified the missing documentation and stated that all sections should be completed. .	L1145		
L1150	322-180.1D PHYSICIAN AUTHORIZATION WAC 246-322-180 Patient Safety and Seclusion Care. (1) The licensee shall assure seclusion and restraint are used only to the extent and duration necessary to ensure the safety of patients, staff, and property, as follows: (d) Staff shall notify, and receive authorization by, a physician within one hour of initiating patient restraint or seclusion; This Washington Administrative Code is not met as evidenced by: . Based on review of medical records and interview, the hospital failed to ensure that a licensed provider wrote an order for restraints for 2 of 6 records reviewed (Patient #522 and #902). Failure of a provider to write an order for the use of restraints could lead to poor documentation and monitoring for patient's condition. Findings included: 1. Document review of the hospital's policy titled, "Use of Restraints," effective 05/17, showed that restraints must be ordered by a physician.	L1150		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	013134	A. BUILDING: _____ B. WING _____	03/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMOKEY POINT BEHAVIORAL HOSPITAL	3955 156TH ST NE MARYSVILLE, WA 98271

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L1150	Continued From page 80 2. Surveyor #9 reviewed the medical records of five patients placed in restraints. Patient #902 did not have an order for a restraint placed on 12/27/17. 3. On 03/14/18, Surveyor #5 reviewed the medical record for Patient #522 who was admitted on 02/11/18 for the treatment of Schizophrenia, Audio and Visual Hallucinations and Paranoid Delusions. The record review showed seven episodes of restraint or seclusion from 02/18/18 to 02/23/18. The reviewed showed that two of seven episodes were missing a physician order for the restraint. -On 03/13/18 at 9:35 AM, a Registered Nurse (Staff #513) verified the finding.	L1150		
L1260	322-200.3E RECORDS-SIGNED ORDERS WAC 246-322-200 Clinical Records. (3) The licensee shall ensure prompt entry and filing of the following data into the clinical record for each period a patient receives inpatient or outpatient services: (e) Authenticated orders for: (i) Drugs or other therapies; (ii) Therapeutic diets; and (iii) Care and treatment, including standing medical orders used in the care and treatment of the patient, except standing medical emergency orders; This Washington Administrative Code is not met as evidenced by: . Based on record review, and review of hospital policy and procedure, the hospital staff failed to	L1260		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	013134	A. BUILDING: _____ B. WING _____	03/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMOKEY POINT BEHAVIORAL HOSPITAL	3955 156TH ST NE MARYSVILLE, WA 98271

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L1260	Continued From page 81 document patient care consistent with provider orders. . Failure of hospital staff to document patient care activities consistent with provider orders puts patients at risk of harm from inadequate care and monitoring. . Findings included: . 1. Document review of the hospital's policy titled, "Physician's Orders," effective 05/17, showed that the nurse would transcribe medication and treatment orders. . 2. Surveyor #9 reviewed the medical record of Patient #909, who was admitted 03/03/18. At the time of admission, the record showed that the admitting provider ordered measurement of daily intake and output and that the staff should encourage fluid intake. The intake and output records for 03/05, 03/06, 03/07, 03/08, 03/09 showed that the patient's intake of fluid was measured, but there was no measure of the patient's output of fluids consistent with the provider's orders. . 3. Surveyor #9 reviewed the medical record of Patient #910 which showed that the patient had ongoing vaginal bleeding possibly related to being postpartum (after having a baby). On 03/03/18 at 10:25 AM, a provider wrote an order to check the number of pads the patient was using for vaginal bleeding. The medical record review showed no record of a pad count prior to the patient being sent to the Emergency Room for evaluation at 2:30 PM.	L1260		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	013134	A. BUILDING: _____ B. WING _____	03/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMOKEY POINT BEHAVIORAL HOSPITAL	3955 156TH ST NE MARYSVILLE, WA 98271

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L1265	Continued From page 82	L1265		
L1265	322-200.3F RECORDS-OBSERVATIONS WAC 246-322-200 Clinical Records. (3) The licensee shall ensure prompt entry and filing of the following data into the clinical record for each period a patient receives inpatient or outpatient services: (f) Significant observations and events in the patient's clinical treatment; This Washington Administrative Code is not met as evidenced by: . Based on interview and medical record review, the hospital failed to document necessary information regarding patient safety incidents into patients' medical records. Failure to maintain a complete information about a patient's health status in their medical record risks substandard care and poor outcomes. Findings included: 1. Document review of the hospital's policy titled, "CPR Code Blue," effective date 05/17, showed that all CPR- certified personnel have the responsibility for initiating emergency resuscitation and maintaining a Code Blue in the event it is required and that a code blue response form is to be utilized and placed in the medical record . Document review of the hospital's policy and procedure titled, "Observation Levels," effective date 05/17, showed that there are specific protocols and required documentation for each observation level. Reasons for the levels of awareness included suicide risk, homicide risk, falls risk, potential for aggressive behavior, or	L1265		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	013134	A. BUILDING: _____ B. WING _____	03/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMOKEY POINT BEHAVIORAL HOSPITAL	3955 156TH ST NE MARYSVILLE, WA 98271

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L1265	Continued From page 83 sexually "acting out" behavior. 2. Surveyor #5 reviewed the medical record of Patient #505. The record review showed the following: On 02/16/2018 at 3:15 PM, Patient #505 attempted suicide by hanging himself with his bed sheets. Documentation from a nursing report showed that the patient was found down with a sheet tightened around his neck and staff called a code blue. The report showed that the patient was initially unresponsive but responded to sternal rub and the patient was transported to an Emergency Department at a medical hospital via ambulance Surveyor #5 was unable to locate the Daily Nursing Progress Note and Nursing Assessment for 02/16/18 in the medical record . Surveyor #5 was unable to located the Code Blue documentation in the medical record . On 03/06/18 at 4:00 PM, Surveyor #5 interviewed the Chief Nursing Officer (CNO) (Staff #501) about the suicide attempt. At the time of the interview, Surveyor #5 and Staff #501 reviewed the chart for patient #505 for the missing documentation, including the Daily Nursing Progress Note and Nursing Assessment for 02/16/18, the Code Blue documentation for the suicide attempt on 02/16/18, and the lack of documentation by nursing about the attempted suicide event in the patient's medical record. Staff #501 confirmed the missing nursing documentation and stated there would be no code documentation because this would not be considered a code.	L1265		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	013134	A. BUILDING: _____ B. WING _____	03/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMOKEY POINT BEHAVIORAL HOSPITAL	3955 156TH ST NE MARYSVILLE, WA 98271

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L1265	Continued From page 84 3. On 03/07/18 at 11:08 AM, Surveyor #5 and a Registered Nurse (Staff #508) reviewed the medical record for Patient #508 who was admitted on 02/15/18 for the treatment of post-traumatic stress disorder, depression, and suicide attempt. The medical record showed the following: The Intake Assessment completed on admission showed that the patient had self-harm behavior, a history of suicide attempts, and had taken a knife with her to her provider appointment and made threats to stab herself. The patient was assessed at high risk for suicide. On 02/17/18 at 11:00 AM, a Psychiatric Progress Note stated, "(Patient #508) attempted to hang herself this a.m., and verbalizes her continued desire to die as she no longer wants to deal with her mental illness." Surveyor #5 found no evidence of this event in the Nursing Progress Notes or Assessment . .	L1265		
L1375	322-210.3C PROCEDURES-ADMINISTER MEDS WAC 246-322-210 Pharmacy and Medication Services. The licensee shall: (3) Develop and implement procedures for prescribing, storing, and administering medications according to state and federal laws and rules, including: (c) Administering drugs; This Washington Administrative Code is not met as evidenced by: .	L1375		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	013134	A. BUILDING: _____ B. WING _____	03/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMOKEY POINT BEHAVIORAL HOSPITAL	3955 156TH ST NE MARYSVILLE, WA 98271

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L1375	Continued From page 85 Item #1- Patient Identification Based on observation, interview, and document review, the hospital failed to ensure all hospital staff members followed its procedure for identification of patients prior to medication administration, as demonstrated by 4 of 4 patients observed (Patients #301, #302, #520, #521). Failure to follow the hospital's patient identification process places patients at risk for medication errors and patient harm. Findings included: 1. Document review of the hospital's policy and procedure titled, "Patient Identifiers," no policy number, effective 05/17, showed that when administering medications, the staff will use two patient identifiers. The hospital's approved patient identifiers are the patient's picture, the patient's name as given by the patient with an alternate identifier being the patient birth date. 2. On 03/12/18 at 2:20 PM, Surveyor #3 observed a medication administration for two patients (Patient #301, #302). The observation showed that the licensed practical nurse (Staff #304) failed to use two patient identifiers prior to administering their medication. In both cases, the staff member called the patients by their first name, rather than asking them to state their name or use another identifier. When asked by Surveyor #3 why she failed to use two patient identifiers, Staff #304 indicated that she knew the patients and could always check the picture or ask them their room number if she had questions.	L1375		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	013134	A. BUILDING: _____ B. WING _____	03/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMOKEY POINT BEHAVIORAL HOSPITAL	3955 156TH ST NE MARYSVILLE, WA 98271

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L1375	Continued From page 86 3. On 03/13/18 from 9:14 to 9:20 AM, Surveyor #5 observed medication administration for two patients (Patient #520, #521). The registered nurse (Staff #512) failed to use two patient identifiers prior to administering the medications. 4. Following the medication administration, Surveyor #5 interviewed Staff #512 about the hospital's policy and procedure for patient identification. The nurse stated, "We don't spend a lot of time on patient identification, I've been working here for three weeks, it's not pure policy." Item #2- Transcribing to the Medication Administration Record Based on document review and review of hospital policy and procedures, the hospital staff failed to follow its procedure for transcribing and verifying physician orders to the medication administration record for 5 of 5 patient records reviewed (Patient #303, #304, #305, #306, and #307). Failure to transcribe and process physician orders correctly places patients at risk for medication errors and patient harm. Findings included: 1. Document review of the hospital's policy and procedure titled, "Physician Orders," no policy number, effective 05/17, showed that the nurse will transcribe medication and treatment orders. Any medication order transcribed to the medication administration record (MAR) is to be checked for accuracy by a second nurse during the chart check (at shift change and 24-hour chart check).	L1375		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	013134	A. BUILDING: _____ B. WING _____	03/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMOKEY POINT BEHAVIORAL HOSPITAL	3955 156TH ST NE MARYSVILLE, WA 98271

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L1375	Continued From page 87 2. On 03/13/18 at 11:30 AM, Surveyor #3 reviewed the MAR for five patients and noted the following: a. Patient #303 was admitted on 03/02/18 and had 8 medication orders not verified by a second nurse at shift change. b. Patient #304 was admitted on 03/01/18 and had 20 medication orders not verified by a second nurse at shift change. c. Patient #305 was admitted on 03/01/18 and had 9 medication orders not verified by a second nurse at shift change. d. Patient #306 was admitted on 03/03/18 and had 8 medication orders not verified by a second nurse at shift change. e. Patient #307 was admitted on 03/09/18 and had 3 medication orders not verified by a second nurse at shift change. 3. On 03/13/18 at 12:30 PM, Surveyor #11 reviewed the medical record of Patient #308. The review showed that a medication order for magnesium citrate 300 ml (a laxative) was transcribed incorrectly to the MAR as magnesium citrate 150 ml. No initials were present to indicate who had transcribed the order to the MAR and no initials were present to verify the physician order had been transcribed correctly. The surveyor asked the nurse (Staff #305) which staff member transcribed the order to the MAR. Staff #305 stated that the hospital unit clerk (Staff #308) transcribed the order. The nurse acknowledged that he failed to verify the	L1375		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	013134	A. BUILDING: _____ B. WING _____	03/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMOKEY POINT BEHAVIORAL HOSPITAL	3955 156TH ST NE MARYSVILLE, WA 98271

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L1375	Continued From page 88 physician order before administering the medication, as required by hospital policy. Staff #305 confirmed with the surveyor that he gave the correct medication amount and corrected the MAR.	L1375		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	504012	A. BUILDING **01 - FED REG SET** B. WING _____	**03/14/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMOKEY POINT BEHAVIORAL HOSPITAL	**3955 156TH ST NE MARYSVILLE, WA 98271**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS This report is the result of an unannounced Fire and Life Safety re-certification survey conducted at Smokey Point Behavioral Hospital on 2/7/2018 by a representative of the Washington State Patrol, Fire Protection Bureau. The survey was conducted in concert with the Washington State Department of Health Services (DOH) health survey teams. The facility has a total of 115 beds and at the time of this survey the census was 80. The New section of the 2012 Life Safety Code was used in accordance with 42 CFR 483.70. The facility consisted of a Type II-A two story structure, fully sprinkled with an automatic fire alarm system in place. Exit discharge points are to grade and stairways to grade having an all-weather surface and lead to a public way. There were no deficiencies identified during the survey. All required fire drills have been conducted and documented properly. The surveyor was: Donald L West Deputy State Fire Marshal	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Smokey Point Behavioral Hospital
Plan of Correction for
State Licensing Psychiatric Hospital Survey

Tag Number	How the Deficiency Will Be Corrected	Responsible Individual(s)	Estimated Date of Correction	Target for Compliance	Action Level Indicating Need for Change of POC